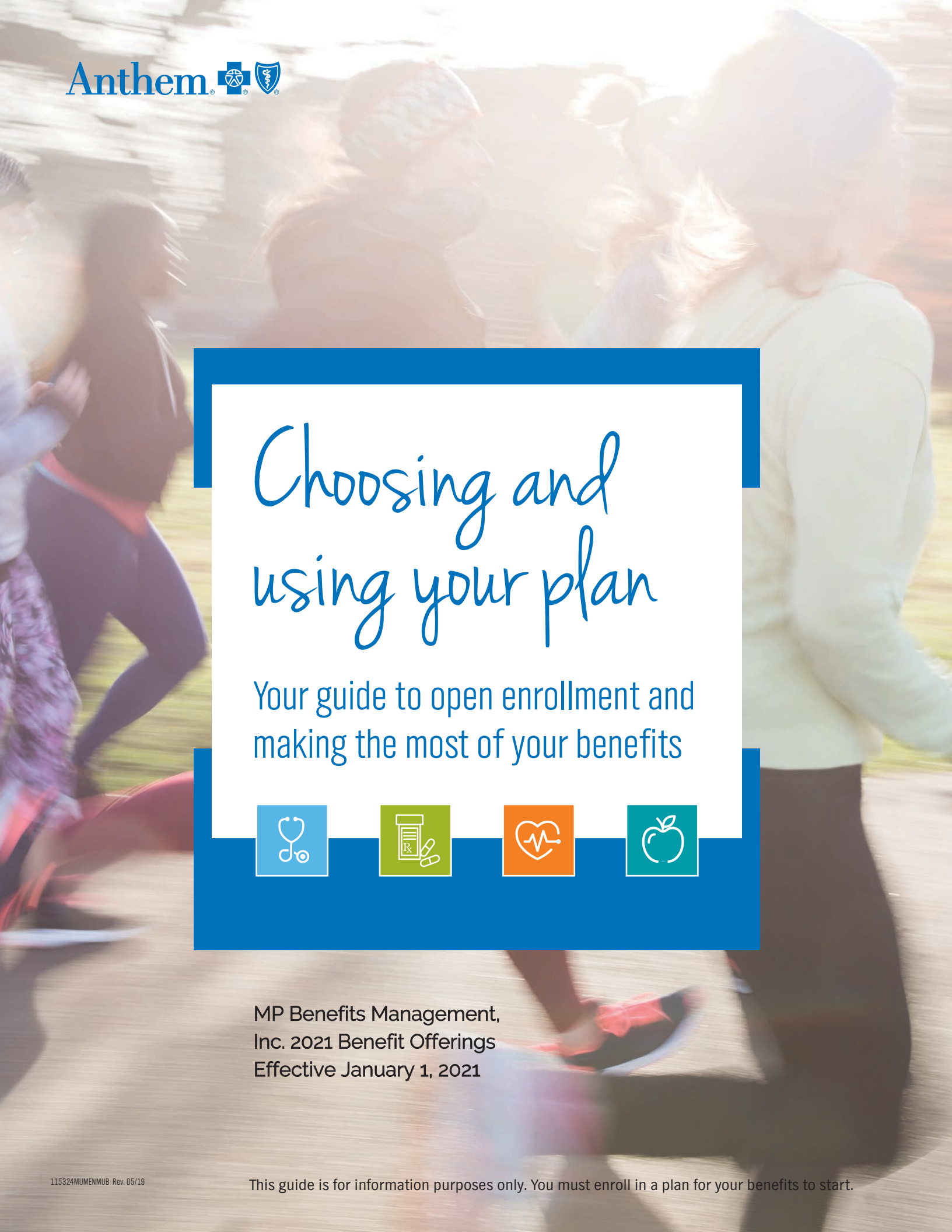


Anthem

Choosing and using your plan

Your guide to open enrollment and making the most of your benefits

MP Benefits Management, Inc. 2021 Benefit Offerings
Effective January 1, 2021

115324MUMENMUB Rev. 05/19

This guide is for information purposes only. You must enroll in a plan for your benefits to start.

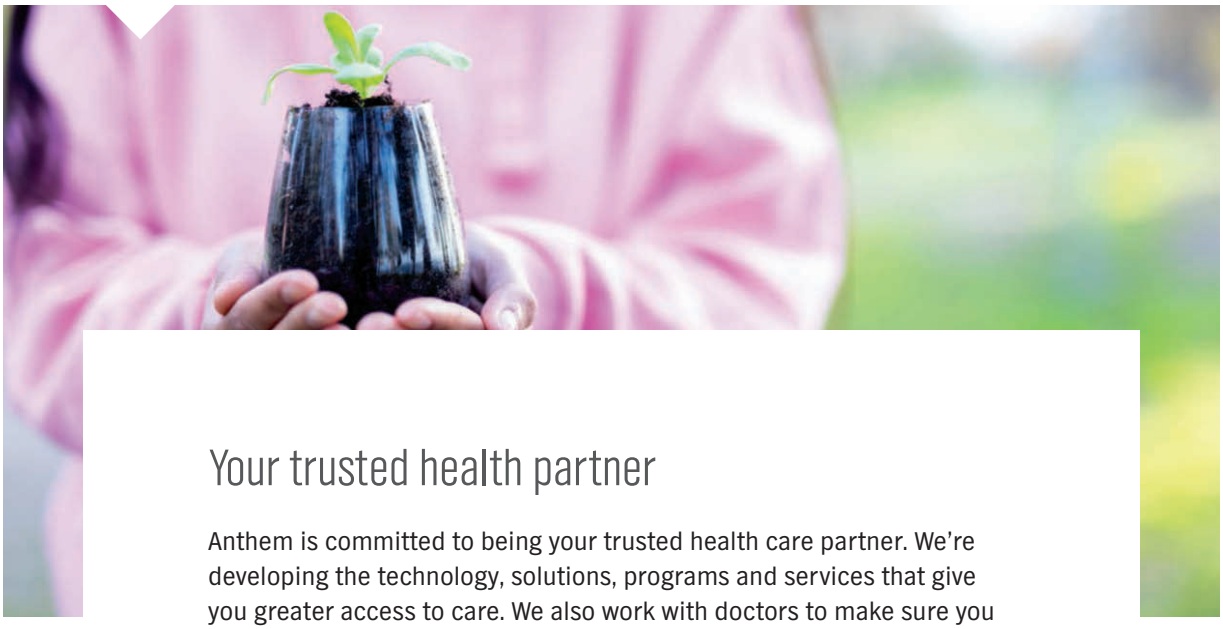
Managepoint

Monthly Rates

Renewal Rates:
1/1/21 - 12/31/21

Anthem Plan 1 - $2750/$8250 Deductible, 60/40 Co-Ins.		
Employee Only	$	247.39
Employee /Spouse	$	549.47
Employee/Child	$	471.97
Family	$	799.05
Anthem Plan 2 - $5250/$10500 Deductible, H.S.A. 80/20 Co-Ins.		
Employee Only	$	119.29
Employee/Spouse	$	264.99
Employee/Child	$	227.62
Family	$	384.74
Anthem Plan 3 - $1750/$5250 Deductible, 70/30 Co-Ins.		
Employee Only	$	313.37
Employee/Spouse	$	694.02
Employee/Child	$	595.44
Family	$	1,008.93
Anthem Plan 4 - $2950/$5900 Deductible, H.S.A., 80/20 Co Ins.		
Employee Only	$	184.20
Employee/Spouse	$	408.89
Employee/Child	$	351.11
Family	$	593.85
Anthem Dental		
Employee Only	$	38.69
Employee /Spouse	$	94.65
Employee/Child	$	91.55
Family	$	125.12
Anthem Vision		
Employee Only	$	7.17
Employee/Spouse	$	12.17
Employee/Child	$	12.86
Family	$	16.08
Epic Basic $25,000 Life		
Employee	$	-

It’s time to choose your plan



Your trusted health partner

Anthem is committed to being your trusted health care partner. We’re developing the technology, solutions, programs and services that give you greater access to care. We also work with doctors to make sure you get affordable, quality health care.

Save this guide

You’ll find tips on how to make the most of your benefits and save on health care costs throughout the year.

It's time to choose your plan

Let's get started

This is the perfect time to think about your health — where you are right now and where you want to be tomorrow. It's your opportunity to check out the benefits, programs and resources that can support your health and well-being all year long.

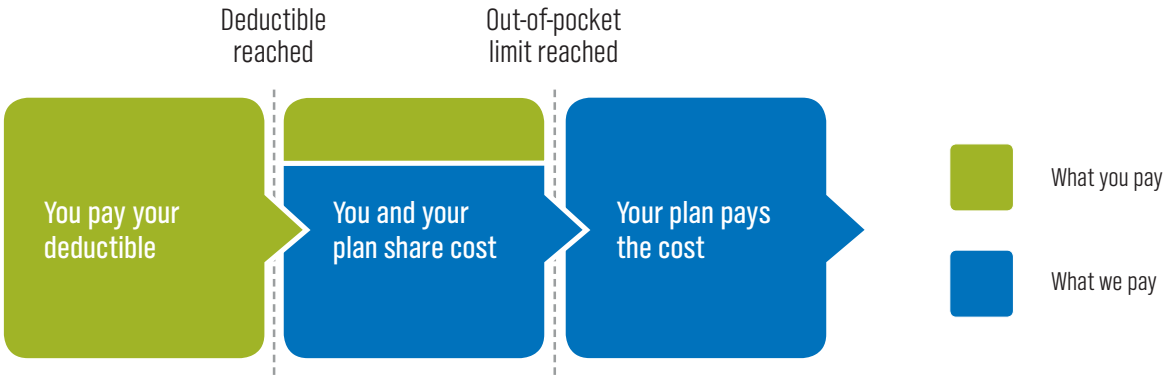
This guide will help you understand our plans. It's also full of tips, tools and resources that can help you reach your health and wellness goals when you become a member. So keep it handy to make the most of your benefits throughout the year.

Table of contents

The basics explained

Before we dive into the plan details, it may be helpful to review some health benefit basics.

What you pay and what your plan pays



This chart is only an example. Your actual cost share will depend on your plan, the service you get and the doctor you choose. Check your plan details to see your actual share of the cost.

Words that are helpful to know

We can help you crack the code of health insurance lingo. Here are the meanings of some common terms:

Deductible:

A set amount you pay each year for covered services before your plan starts to pay for covered health care costs.

You can use your HSA/FSA/HRA toward your deductible.

Copay:

A flat fee you pay for covered services like doctor visits.

Coinsurance:

Once you've met your deductible, you and your health plan share the cost of covered health care services. The coinsurance is your share of the costs, usually a percent of the cost of care. Your plan details show what portion of the cost you'll pay.

Out-of-pocket limit:

This is the most you have to pay out of your own pocket each year for covered services. This amount may include your deductible and your percentage of the costs, depending on your plan. And some plans may still have you pay a copay at the time of service.

Premium:

The premium, also called a monthly payment, is what you pay for the plan. It's the money that comes out of your paycheck. Think of it like a membership fee that's separate from what you pay when you get care.

Explore your plan options

Here's the part where you get to look at the plans and find the one that fits. What works best for you and your family?

Plan 1 - PPO

With a Preferred Provider Organization (PPO), you can go to almost any doctor or hospital — giving you more choices and flexibility.

- You can choose a primary care doctor (PCP) from the plan for preventive care like checkups and screenings.
- You don't need to have a PCP to see a specialist.
- When you want to see a specialist, like an orthopedic doctor or a cardiologist, you don't need to visit your PCP first to get a referral. This can save you time and a copay.
- You'll pay less if you use doctors who are part of the PPO.
- You'll pay more if you go to doctors who aren't part of the PPO.

Plan 2 - HSA

An HSA allows you to set aside pre-tax dollars to pay for care when you need it, now or in the future. You can use money in the account to pay for qualified medical expenses like hospital visits, prescription drugs or copays for doctor visit.[1]

- Once you pay your deductible, you'll pay a percentage of the total cost (also called coinsurance) anytime you get care for a covered service. Your plan will cover the rest.
- All the money in your HSA rolls over from year to year, and it's yours even if you change health plans, jobs or retire.
- The money you put into your HSA, any interest you earn and even the money you take out to pay for health care is all tax-free.
- You can contribute up to $3,550 for individuals and $7,100 for families.[1]
- If you're 55 or older you can contribute an extra $1,000 a year.

Watch our HSA Basics video to learn more.

1. For a full list of qualified expenses for an individual, visit **anthem.com/qme**. Veterans who have received medical benefits from the VA, due to a service-connect disability, are eligible to receive or make HSA contributions. Visit the IRS website at irs.gov/irb/2004-33/IRB for more information.

Explore your plan options

Plan 3 - PPO

With a Preferred Provider Organization (PPO), you can go to almost any doctor or hospital — giving you more choices and flexibility.

- You can choose a primary care doctor (PCP) from the plan for preventive care like checkups and screenings.
- You don't need to have a PCP to see a specialist.
- When you want to see a specialist, like an orthopedic doctor or a cardiologist, you don't need to visit your PCP first to get a referral. This can save you time and a copay.
- You'll pay less if you use doctors who are part of the PPO.
- You'll pay more if you go to doctors who aren't part of the PPO.

Plan 4 - HSA

An HSA allows you to set aside pre-tax dollars to pay for care when you need it, now or in the future. You can use money in the account to pay for qualified medical expenses like hospital visits, prescription drugs or copays for doctor visit.[1]

- Once you pay your deductible, you'll pay a percentage of the total cost (also called coinsurance) anytime you get care for a covered service. Your plan will cover the rest.
- All the money in your HSA rolls over from year to year, and it's yours even if you change health plans, jobs or retire.
- The money you put into your HSA, any interest you earn and even the money you take out to pay for health care is all tax-free.
- You can contribute up to $3,550 for individuals and $7,100 for families.[1]
- If you're 55 or older you can contribute an extra $1,000 a year.

Watch our HSA Basics video to learn more.

1. For a full list of qualified expenses for an individual, visit **anthem.com/qme**. Veterans who have received medical benefits from the VA, due to a service-connect disability, are eligible to receive or make HSA contributions. Visit the IRS website at irs.gov/irb/2004-33/IRB for more information.

Your pharmacy benefits

What your plan will cover

It's easy to get what you need, whether you take medicine every day or only once in a while.

Your pharmacy plan includes:

- One or more drugs lists. Be sure to check for your medications – the brand-name drugs and the generics that are included in your plan.
  - You can find out if the drug you take is included on the **Essential 4-tier** Drug List by visiting **anthem.com/abs/essentialdruglist**.

How your pharmacy benefits work

You pay your deductible

Your plan options come with a **combined medical and pharmacy deductible**. That means you'll have to pay the full cost for your covered drugs until you meet 100% of your annual deductible. The cost you pay out of your pocket for covered drugs and covered medical care will go towards meeting your annual deductible. Your plan will start to share the cost of your covered medicine and covered medical care after you reach your deductible.

You and your plan share the costs

After you meet your deductible, your plan will share the cost of medicine. Your options include plans with different ways of sharing the cost:

- **Copays:** You pay a set amount, or copay, for medicine. Your copay will be based on which tier the drug is on. See Save money with Tier 1 drugs to learn more.
- **Coinsurance:** You pay a certain percentage of the drug's cost, which can be different based on the pharmacy you use.

Your pharmacy benefits

Save money with Tier 1 drugs

Prescription medicines or drugs are listed in groups called tiers. Your cost is based on which tier the drug is in. Tiers 1 and 2 usually include low-cost and generic drugs. You'll save the most money when you use Tier 1 drugs.

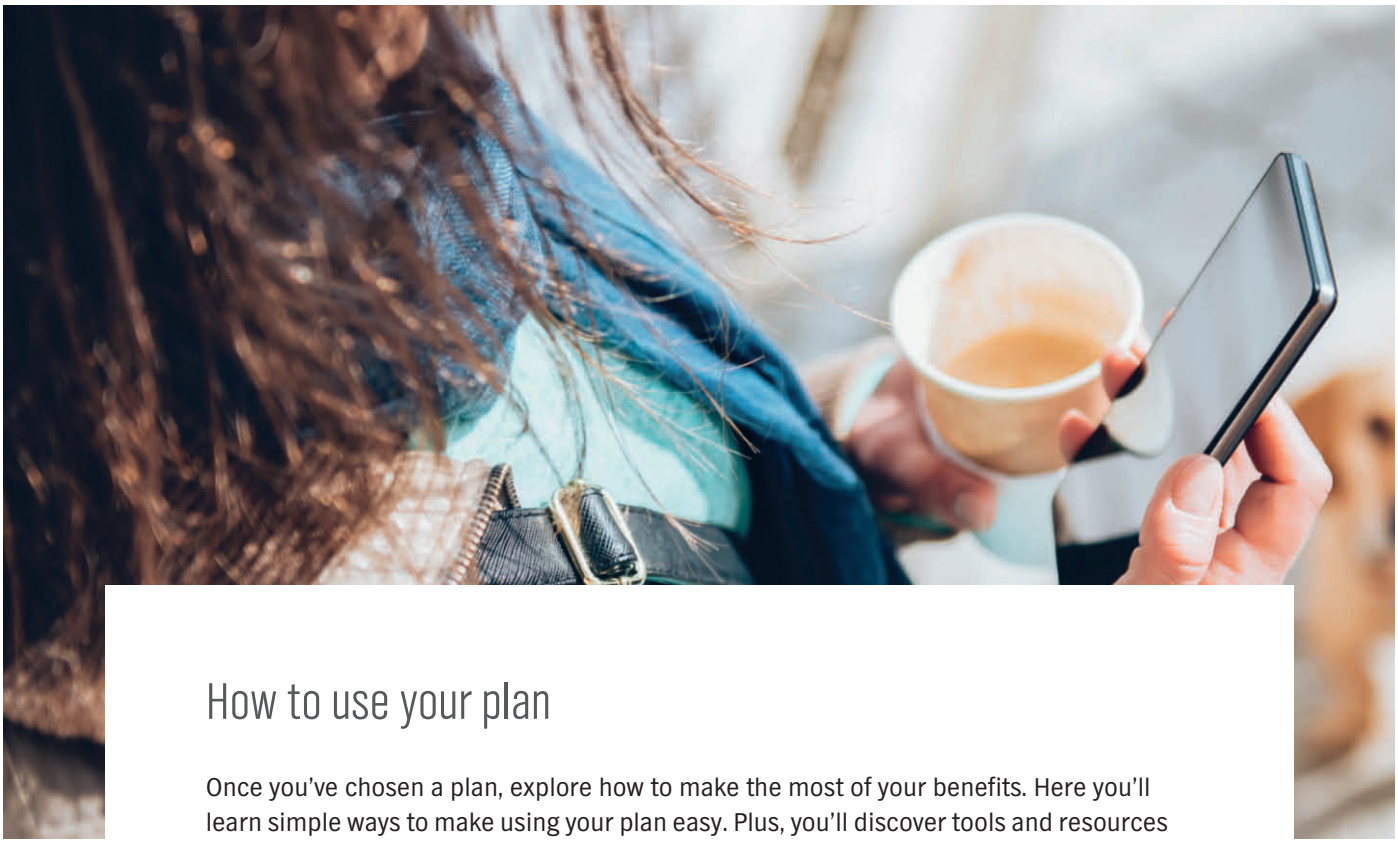
Once you're a member, you can check the price of a drug at different pharmacies at **anthem.com** and see if there are lower-cost drugs.

	Drug type	Cost
Tier 1	Preferred generic	$
Tier 2	Preferred brand name and newer, more expensive generic drugs	$$
Tier 3	Nonpreferred brand name and generic drugs	$$$
Tier 4	Preferred specialty drugs (brand name and generic)	$$$$

Simple ways to save money on medicine

- Use home delivery for drugs you take on a regular basis.
- Find a pharmacy in your plan.
- Talk to your doctor about generic medicines.
- See if an over-the-counter option is available.

Using your plan



How to use your plan

Once you've chosen a plan, explore how to make the most of your benefits. Here you'll learn simple ways to make using your plan easy. Plus, you'll discover tools and resources that can help you reach your health and wellness goals. With Anthem, supporting your healthiest self is all part of the plan!

How to use your plan

Use your ID card right from your phone

Introducing the **Sydney Health** mobile app. With **Sydney Health** you can find everything you need to know about your benefits – all in one place. You'll have a custom experience that's based on your plan, your specific health care needs and lots more. And you can quickly access your digital ID card to show it to your doctor or pharmacy. You can even use **Sydney Health** to track your health goals, find care, compare costs, and manage your claims.

Have a question? **Sydney Health** acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly. **Sydney Health** makes it easier to get things done, so you can spend more time focusing on your health. Get started by downloading the **Sydney Health** mobile app.

Register for online tools and resources

Accessing your health plan on your mobile phone or computer makes life so much easier. Register on the **Sydney Health** mobile app and **anthem.com** to get personalized information about your health plan and more. You can:

- Quickly access your digital ID card.
- Find a doctor and estimate your costs before you go.
- Look at your prescription drug benefits, check the price of a drug and find a pharmacy near you that's in your plan.
- View your claims, see what's covered and what you may owe for care.
- Check your spending account balances.
- Get support managing your health conditions and tracking your goals.
- Update your email and communication preferences.

How to use your plan

Find a doctor in your plan

The right doctor can make all the difference — and choosing one in your plan can save you money, too. So you'll be happy to know your plan includes lots of top-notch doctors. If you decide to get care from doctors outside the plan, it'll cost you more and your care might not be covered at all.

It's easy to find a doctor in your plan. Simply use the **Find a Doctor** tool on the **Sydney Health** mobile app or at **anthem.com** to search for doctors, hospitals, labs and other health care professionals.

Schedule a checkup

Preventive care, like regular checkups and screenings, can help you avoid health problems down the road. Your plan covers these services at little or no extra cost when you see a doctor in your plan:

- Yearly physicals
- Well-child visits
- Flu shot
- Routine shots
- Screenings and tests

Check your plan details on the **Sydney Health** mobile app or **anthem.com** to confirm what preventive care is covered.

Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO | Plan 1 | MP Benefits Management

Your Network: Blue Access | Effective: 01/01/2021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *The deductible for In-Network and Non-Network are added separately and do not apply towards each other.*	$2,750 person / $8,250 family	$5,250 person / $15,250 family
Out-of-Pocket Limit *The Out-of-Pocket limit for In-Network and Non-Network are added separately and do not apply towards each other.*	$6,500 person / $13,000 family	$19,500 person / $39,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	60% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $30 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$30 copay per visit deductible does not apply	60% coinsurance after deductible is met
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $55 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$55 copay per visit deductible does not apply	60% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit deductible does not apply	60% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit deductible does not apply	60% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit deductible does not apply	60% coinsurance after deductible is met
Manipulation Therapy *Coverage for Physical Therapy, Occupational Therapy, Speech Therapy and Manipulation are limited to 60 visits combined per benefit period.*	$55 copay per visit deductible does not apply	60% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Chemo/Radiation Therapy - PCP	$30 copay per visit deductible does not apply	60% coinsurance after deductible is met
Chemo/Radiation Therapy - Specialist	$55 copay per visit deductible does not apply	60% coinsurance after deductible is met
Dialysis/Hemodialysis	No charge	60% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	No charge	60% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	60% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	40% coinsurance after deductible is met	60% coinsurance after deductible is met
X-Ray:		
Office	No charge	60% coinsurance after deductible is met
Outpatient Hospital	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Freestanding Radiology Center	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Outpatient Hospital	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *When Allergy injections are billed separately by network providers, the member is responsible for a $30 PCP copay/$55 SCP copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$75 copay per visit deductible does not apply	60% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	40% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	40% coinsurance after deductible is met	Covered as In-Network
Ambulance	40% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit deductible does not apply	60% coinsurance after deductible is met
Facility visit:		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility Fees	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Doctor Services	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Freestanding Surgical Center	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Freestanding Surgical Center	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility fees	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	No charge	50% coinsurance after deductible is met
Doctor and other services	40% coinsurance after deductible is met	60% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 100 visits per benefit period.*	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Rehabilitation services: Office *Coverage for Physical Therapy, Occupational Therapy, Speech Therapy and Manipulation are limited to 60 visits combined per benefit period.*	$55 copay per visit deductible does not apply	60% coinsurance after deductible is met
Outpatient Hospital *Coverage for Physical Therapy, Occupational Therapy, Speech Therapy and Manipulation are limited to 60 visits combined per benefit period.*	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.*	$55 copay per visit deductible does not apply	60% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Skilled Nursing Care (facility) *Skilled Nursing is limited to 120 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Hospice	No charge	No charge
Durable Medical Equipment	40% coinsurance after deductible is met	60% coinsurance after deductible is met
Prosthetic Devices	40% coinsurance after deductible is met	60% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use a Non-Network Provider
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with Non-Network medical
Prescription Drug Coverage *National w/R90 with Optional Home Delivery* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$15 copay per prescription, deductible does not apply (retail) and $30 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription, deductible does not apply (retail) and $100 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	50% coinsurance up to $200 per prescription, deductible does not apply (retail) and 50% coinsurance up to $400 per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	50% coinsurance up to $500 per prescription, deductible does not apply (retail and home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Your Plan: Anthem Blue Access PPO Option 20 with Rx Option T6

Your Network: Blue Access

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA (with Copay) Plan 2 MP Benefits Management

Your Network: Blue Access Effective: 01/01/2021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *The deductible for In-Network and Non-Network are added separately and do not apply towards each other.*	$5,250 person / $10,500 family	$10,250 person / $20,250 family
Out-of-Pocket Limit *The Out-of-Pocket limit for In-Network and Non-Network are added separately and do not apply towards each other.*	$6,550 person / $13,100 family	$15,000 person / $30,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	60% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for $30 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$30 copay per visit after deductible is met	60% coinsurance after deductible is met
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for $55 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$55 copay per visit after deductible is met	60% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit after deductible is met	60% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit after deductible is met	60% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit after deductible is met	60% coinsurance after deductible is met
Manipulation Therapy *Coverage for Physical Therapy, Occupational Therapy, Speech Therapy and Manipulation are limited to 60 visits combined per benefit period.*	$55 copay per visit after deductible is met	60% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Chemo/Radiation Therapy - PCP	$30 copay per visit after deductible is met	60% coinsurance after deductible is met
Chemo/Radiation Therapy - Specialist	$55 copay per visit after deductible is met	60% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	60% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray:		
Office	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *When Allergy injections are billed separately by network providers, the member is responsible for $30 PCP copay/$55 SCP copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$75 copay per visit after deductible is met	60% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$125 copay per visit after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit after deductible is met	60% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	60% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility fees	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	60% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Rehabilitation services:		
Office *Coverage for Physical Therapy, Occupational Therapy, Speech Therapy and Manipulation Therapy are limited to 60 visits combined per benefit period.*	$55 copay per visit after deductible is met	60% coinsurance after deductible is met
Outpatient Hospital *Coverage for Physical Therapy, Occupational Therapy, Speech Therapy and Manipulation Therapy are limited to 60 visits combined per benefit period.*	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period.*	$55 copay per visit after deductible is met	60% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Skilled Nursing Care (facility) *Skilled Nursing is limited to 90 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	Covered as In-Network
Durable Medical Equipment	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	60% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with Non-Network medical
Prescription Drug Coverage *National w/R90 with Optional Home Delivery* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$15 copay per prescription after deductible is met (retail) and $30 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription after deductible is met (retail) and $100 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	50% coinsurance up to $200 per prescription, deductible does not apply (retail) and 50% coinsurance up to $400 per prescription, deductible does not apply (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	50% coinsurance up to $500 per prescription, deductible does not apply (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Your Plan: Anthem Blue Access PPO HSA (with Copay) Option E4 with Rx Option T8

Your Network: Blue Access

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO | Plan 3 | MP Benefits Management

Your Network: Blue Access | Effective: 01/01/2021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *The deductible for In-Network and Non-Network are added separately and do not apply towards each other.*	$1,750 person / $5,250 family	$3,250 person / $9,250 family
Out-of-Pocket Limit *The Out-of-Pocket limit for In-Network and Non-Network are added separately and do not apply towards each other.*	$5,000 person / $10,000 family	$10,000 person / $20,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $30 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $55 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$55 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy *Coverage for Physical Therapy, Occupational Therapy, Speech Therapy and Manipulation are limited to 60 visits combined per benefit period.*	$55 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy - PCP	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy - Specialist	$55 copay per visit deductible does not apply	50% coinsurance after deductible is met
Dialysis/Hemodialysis	No charge	50% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	No charge	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *When Allergy injections are billed separately by network providers, the member is responsible for a $30 PCP copay/$55 SCP copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$75 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	30% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	30% coinsurance after deductible is met	Covered as In-Network
Ambulance	30% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility visit:		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility Fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	No charge	50% coinsurance after deductible is met
Doctor and other services	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 100 visits per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services: Office *Coverage for Physical Therapy, Occupational Therapy, Speech Therapy and Manipulation are limited to 60 visits combined per benefit period.*	$55 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Physical Therapy, Occupational Therapy, Speech Therapy and Manipulation are limited to 60 visits combined per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.*	$55 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Skilled Nursing is limited to 120 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	No charge	No charge
Durable Medical Equipment	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use a Non-Network Provider
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with Non-Network medical
Prescription Drug Coverage *National w/R90 with Optional Home Delivery* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$15 copay per prescription, deductible does not apply (retail) and $30 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription, deductible does not apply (retail) and $100 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	50% coinsurance up to $200 per prescription, deductible does not apply (retail) and 50% coinsurance up to $400 per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	50% coinsurance up to $500 per prescription, deductible does not apply (retail and home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Your Plan: Anthem Blue Access PPO Option 15 with Rx Option T3

Your Network: Blue Access

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA (with Copay) Plan 4 MP Benefits Management

Your Network: Blue Access Effective: 01/01/2021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *The deductible for In-Network and Non-Network are added separately and do not apply towards each other.*	$2,950 person / $5,900 family	$5,250 person / $10,250 family
Out-of-Pocket Limit *The Out-of-Pocket limit for In-Network and Non-Network are added separately and do not apply towards each other.*	$6,550 person / $13,100 family	$6,550 person / $13,100 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	60% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for $30 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$30 copay per visit after deductible is met	60% coinsurance after deductible is met
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for $55 SCP copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$55 copay per visit after deductible is met	60% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit after deductible is met	60% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit after deductible is met	60% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit after deductible is met	60% coinsurance after deductible is met
Manipulation Therapy *Coverage for Physical Therapy, Occupational Therapy, Speech Therapy and Manipulation are limited to 60 visits combined per benefit period.*	$55 copay per visit after deductible is met	60% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Chemo/Radiation Therapy - PCP	$30 copay per visit after deductible is met	60% coinsurance after deductible is met
Chemo/Radiation Therapy - Specialist	$55 copay per visit after deductible is met	60% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	60% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray:		
Office	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *When Allergy injections are billed separately by network providers, the member is responsible for $30 PCP copay/$55 SCP copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$75 copay per visit after deductible is met	60% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$125 copay per visit after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit after deductible is met	60% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	60% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility fees	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	60% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Rehabilitation services:		
Office *Coverage for Physical Therapy, Occupational Therapy, Speech Therapy and Manipulation Therapy are limited to 60 visits combined per benefit period.*	$55 copay per visit after deductible is met	60% coinsurance after deductible is met
Outpatient Hospital *Coverage for Physical Therapy, Occupational Therapy, Speech Therapy and Manipulation Therapy are limited to 60 visits combined per benefit period.*	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period.*	$55 copay per visit after deductible is met	60% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Skilled Nursing Care (facility) *Skilled Nursing is limited to 90 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	Covered as In-Network
Durable Medical Equipment	20% coinsurance after deductible is met	60% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	60% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with Non-Network medical
Prescription Drug Coverage *National w/R90 with Optional Home Delivery* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$15 copay per prescription after deductible is met (retail) and $30 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription after deductible is met (retail) and $100 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	50% coinsurance up to $200 per prescription, deductible does not apply (retail) and 50% coinsurance up to $400 per prescription, deductible does not apply (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	50% coinsurance up to $500 per prescription, deductible does not apply (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Your Plan: Anthem Blue Access PPO HSA (with Copay) Option E4 with Rx Option T8

Your Network: Blue Access

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

You've got quick access to your health care!

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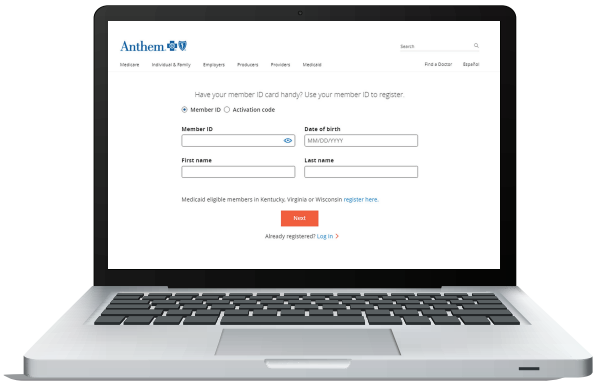

From your computer

1. Go to **anthem.com/register**
2. Provide the information requested
3. Create a username and password
4. Set your email preferences
5. Follow the prompts to complete your registration

From your mobile device

Sydney Health

1. Download the free **Sydney** mobile app and select **Register**
2. Confirm your identity
3. Create a username and password
4. Confirm your email preferences
5. Follow the prompts to complete your registration

It's easy. Everything you need to know about your plan — including medical — in one place. Making your health care journey simple, personal — all about you.

Need help signing up?
Call us at **1-866-755-2680**.

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* You must be 18 years or older to register your own account.

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LiveHealth Online

Quick and easy access to a doctor 24/7

Have you ever been at work and didn't feel well? Maybe you had a fever or a sore throat but you didn't have time to leave and see your doctor or go to urgent care. Now, with LiveHealth Online, you can see a board-certified doctor in minutes.

Just use your smartphone, tablet or computer with a webcam. It's so convenient, almost 90% of people who've used it feel they saved two hours or more and would use it again in the future.[1] Plus, online visits using LiveHealth Online are already part of your Anthem Blue Cross and Blue Shield benefits. To start using LiveHealth Online, all you need to do is sign up at **livehealthonline.com** or download the app.

Sign up for free today and get:

1. **24/7 access to doctors.** They can assess your condition, provide treatment options and even send a prescription to the pharmacy of your choice, if needed.[2] It's a great way to get care when your doctor isn't available.
2. **Medical care when you need it.** For things like the flu, a cold, sinus infection, pink eye, rashes, fever and more.
3. **Convenience.** Since there are no appointments or long waits. In fact, most people are connected to a doctor in about 10 minutes or less.

Doctors using LiveHealth Online typically charge $49 or less per visit, depending on your health plan.

LiveHealth Online Psychology

An easy, convenient way to see a therapist or psychologist in just a few days

If you're feeling stressed, worried, or having a tough time, you can talk to a licensed psychologist or therapist through video using LiveHealth Online Psychology. It's easy to use, private and, in most cases, you can see a therapist within four days or less.[3] All you have to do is sign up at **livehealthonline.com** or download the app to get started. The cost is similar to what you'd pay for an office therapy visit.

Make your first appointment — when it's easy for you

- Use the app or go to **livehealthonline.com** and log in. Select **LiveHealth Online Psychology** and choose the therapist you'd like to see.
- Or, call LiveHealth Online at **1-844-784-8409** from 7 a.m. to 11 p.m.
- You'll get an email confirming your appointment.

Anthem BlueCross BlueShield

LiveHealth® ONLINE

57980ANMENABS VPOD 12/15

LiveHealth Online: what you need to know

What kind of doctors can you see on LiveHealth Online?

Doctors on LiveHealth Online are:

- Board certified with an average of 15 years of practicing medicine
- Mainly primary care physicians
- Specially trained for online visits

When can you use LiveHealth Online?

LiveHealth Online is a great option for care when your own doctor isn't available and more convenient than a trip to the urgent care. With LiveHealth Online, you can receive medical care for things like:

- Cold and flu symptoms, such as a cough, fever and headaches
- Allergies
- Sinus infections and more

How do I pay for an online visit using LiveHealth Online?

LiveHealth Online accepts Visa, MasterCard and Discover cards as payment for an online doctor visit. Keep in mind that charges for prescriptions aren't included in the cost of your doctor visit.

LiveHealth Online Psychology

What conditions can be treated when you have a visit with a psychologist or therapist?

You can get help for these types of conditions:

- Stress
- Anxiety
- Depression
- Family or relationship issues
- Grief
- Panic attacks
- Stress from coping with a sickness

How much does a therapist visit cost?

The cost should be similar to what you'd pay for an office therapy visit, depending on your benefits, copay or coinsurance. You'll see what you owe before you start a visit and any cost is charged to your credit card. The cost is the same no matter when you have the visit — whether it's a weekday, the weekend, evening or a holiday.

How do I decide which therapist to see?

After you log in at **livehealthonline.com** or with the app, select **LiveHealth Online Psychology**. Next, you can read profiles of therapists and psychologists. Once you select the one you would like to see, schedule a visit online or by phone. At the end of the first visit, you can set up future visits with the same therapist if both of you feel it's needed. You always have the choice of the therapist you want to see.

What else do I need to know about LiveHealth Online Psychology?

- You must be at least 18 years old to see a therapist online and have your own LiveHealth Online account.
- Psychologists and therapists using LiveHealth Online do not prescribe medications.
- Visits usually last about 45 minutes.

Get started today

It's quick and easy to sign up for LiveHealth Online. Just go to **livehealthonline.com** or download the mobile app at Google Play™ or the App Store℠.

Download on the App Store

ANDROID APP ON Google play

Enrollment Application
Group size 51+ eligible employees

Anthem BlueCross BlueShield

AnthemLife

INSTRUCTIONS:

Please read carefully, complete electronically, or in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer.

Section 1: Employer/Group Use — Required

Employer name		Employer address		
Group no.	Sub-group no./Life division no.	Requested effective date	Life classification	Employee no./Dept. name

Section 2: Reason for Application — Required

☐ New enrollment ☐ New hire ☐ Add dependent (Fill in Section 3)
☐ Annual open enrollment (N/A to Life) ☐ Rehire – Date:
☐ COBRA – Qualifying event: COBRA event date:
☐ Waiver (To decline ALL coverage skip to Section 11)

Section 3: Status Change/Event — Required, if you checked "Add dependent" option in Section 2.

Event date	☐ Marriage ☐ Birth ☐ Adoption (Attach legal documentation) ☐ Legal guardianship (Attach legal documentation) ☐ Loss of coverage (reason): ☐ Terminated employment ☐ Other:

Section 4: Plan/Type of Coverage — Required. To decline a plan type, check "No coverage". If you are waiving all coverage, go to Section 11.

Medical — If multiple Medical plans are available, please indicate the plan type below and write plan number in the space provided.

☐ HMO ☐ Anthem Essential℠ PPO ☐ Lumenos® HRA PPO ☐ Lumenos® Health Incentive Account Plus PPO
☐ PPO ☐ Lumenos® HSA PPO[1] ☐ Lumenos® HIA PPO ☐ Lumenos® Deductible First HRA PPO

If multiple Medical plans are available, write plan number:

Type of medical coverage: ☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage

Dental — To apply for BUY-UP coverage, check PPO and write in the plan number on the line provided.

☐ PPO: ☐ Dental Blue®100/200/300
☐ Traditional ☐ Dental Blue® 100

Type of dental coverage: ☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage

Vision

Type of vision coverage: ☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage

Life

Fill in Section 7.

Section 5: Employee Information — Required

Last name	First name	M.I.	Social Security no.[2] (required)

Date of birth	Age	Sex ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Divorced	Height	Weight

Home phone no.	Business phone no.	Email address

Street address	City	State	ZIP code	County

Retired? ☐ Yes ☐ No Disabled? ☐ Yes ☐ No Hospitalized? ☐ Yes ☐ No	Occupation	Hours working per week	Full-time hire date	Income reported by: ☐ W-2 ☐ 1099 ☐ Other:

1 Anthem will facilitate the opening of a Health Savings Account (HSA) in your name, if directed by your employer.
2 Anthem is required by the Internal Revenue Service to collect this information.

Reset Form Save and Print

Employee name	Social Security no.[1] (required)

Section 6: Family Information — Required. List only dependents you wish to enroll, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under Section 9, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 6.

Spouse/Domestic Partner

Last name	First name	M.I.	Social Security no.* (required)

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled?
			☐ M ☐ F	☐ Spouse ☐ Domestic Partner	☐ Yes ☐ No If yes, give reason:

If spouse/DP address is different than employee, please provide full address

Dependent

Last name	First name	M.I.	Social Security no.* (required)	Full-time student?
				☐ Yes ☐ No

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled?
			☐ M ☐ F	☐ Child ☐ Other:	☐ Yes ☐ No If yes, give reason:

Court ordered health care coverage?	If dependent address is different than employee, please provide full address
☐ Yes ☐ No (If yes,attach legal documentation)	

Dependent

Last name	First name	M.I.	Social Security no.* (required)	Full-time student?
				☐ Yes ☐ No

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled?
			☐ M ☐ F	☐ Child ☐ Other:	☐ Yes ☐ No If yes, give reason:

Court ordered health care coverage?	If dependent address is different than employee, please provide full address
☐ Yes ☐ No (If yes, attach legal documentation)	

Section 7: Life and Disability Insurance — Required, if this type of coverage was selected in Section 4.

Current Income: $_____ ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Life Class

☐ Basic Life ☐ Optional Life: _____ x Annual Earnings ☐ Basic AD&D ☐ Short Term Disability: _____
☐ Dependent Life OR $_____ ☐ Optional AD&D ☐ Long Term Disability: _____

Anthem ByDesign Buy-Up. Check appropriate box and write in the percentage next to the benefit selected. Complete separate election form.

☐ Short Term Disability: _____% ☐ Long Term Disability: _____% ☐ Basic Life

Primary beneficiary

Last name	First name	M.I.	Social Security no.* (required)	Relationship to employee	Age

Contingent beneficiary

Last name	First name	M.I.	Social Security no.* (required)	Relationship to employee	Age

Section 8: Other Health Coverage — Required

Do you and/or your dependents have other health coverage? ☐ Yes ☐ No If yes, complete below.

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage?

Provide name, phone number and address of the HMO or insurance company	Policy/certificate no.	Effective date

Policy/certificate holder name	Social Security no.* (required)	Date of birth	Relationship to employee

Are you and/or your dependents enrolled in Medicare or Medicaid? ☐ Yes ☐ No If yes, complete below.

Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date

Medicare Part D ID no.	Medicare Part D carrier	Medicare Part D effective date	Medicare Part D term date

Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

1 Anthem is required by the Internal Revenue Service to collect this information.

Employee name	Social Security no.[1] (required)

Have you and/or your dependents had prior health coverage? ☐ Yes ☐ No If yes, complete below.			
Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No	Policy/certificate no.		
Group name/ID no.	Date policy in effect	Date policy termed	
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? ☐ Yes ☐ No			
List prior carrier(s)	Date policy in effect	Date policy termed	
Please check the type of prior coverage ☐ Employee ☐ Employee+Spouse/DP ☐ Employee+Child(ren) ☐ Employee+Spouse/DP+Child(ren)			
Termination reason: ☐ Divorce/legal separation ☐ Employment terminated ☐ Employer/group contribution ceased ☐ Other ☐ Death of spouse/DP ☐ COBRA coverage exhausted ☐ Group plan terminated			

Section 9: Significant Terms, Conditions and Authorizations (TERMS) — Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem Blue Cross and Blue Shield at any time.

1. I understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

I certify each Social Security Number listed on this application is correct.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 10: Signature — Required, if you are applying for coverage. Please review your application for errors or omissions.

Read Section 9 carefully before signing.
I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature	Date
X	

1 Anthem is required by the Internal Revenue Service to collect this information.

Employee name	Social Security no.[1] (required)

Section 11: Waiver of coverage — Complete for yourself and/or any eligible dependents. Check all that apply.

Type of coverage	Waived for	Name	Reason for waiving (already protected by coverage)	
☐ **Medical**	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ **Dental**	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ **Vision**	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ **Life**	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ **All**	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	

Check all that apply:

☐ I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. If I want to apply for such coverage at a later date, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse or domestic partner) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependents or I become eligible for a subsidy (state premium assistance program).

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

☐ I have been given an opportunity to apply for the available group life benefits offered by my employer/group. The benefits have been explained to me, and I and/or my dependent(s) decline to participate. My dependent(s) or I were not induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for coverage in the future, I may be required to provide evidence of insurability at my expense.

Signature — Required, if you want to waive coverage for yourself and your dependents.

Employee signature **X**	Date

1 Anthem is required by the Internal Revenue Service to collect this information.

Your Summary of Benefits
Managepoint LLC
Anthem Dental Complete

WELCOME TO YOUR DENTAL PLAN!
This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your certificate of coverage.

Dental coverage you can count on
Your Anthem dental plan lets you visit any licensed dentist or specialist you want – with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits – you get more for your money.
You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE	In-Network	Out-of-Network
Annual Benefit Maximum – (Calendar Year) • Per insured person Annual Maximum Carryover	 $1,500 No	 $1,500 No
Orthodontic Lifetime Benefit Maximum • Per eligible insured child	$1,500	$1,500
Annual Deductible – (Calendar Year) • Per insured person • Family maximum	$50 3x single member deductible	$50 3x single member deductible
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement	80th percentile	

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services • Periodic oral exam • Teeth cleaning (prophylaxis) • Bitewing X-rays (twice in 12 mos. for all ages) • Intraoral X-rays	100% coinsurance	100% coinsurance	No waiting period
Basic Services • Amalgam (silver-colored) Filling • Front composite (tooth-colored) Filling • Back Composite Filling, alternated to amalgam allowance • Simple Extractions	90% coinsurance	80% coinsurance	No waiting period
Endodontics • Root canal	90% coinsurance	80% coinsurance	No waiting period
Periodontics • Scaling and root planing	90% coinsurance	80% coinsurance	No waiting period
Oral Surgery • Surgical Extractions	90% coinsurance	80% coinsurance	No waiting period
Major Services • Crowns	60% coinsurance	50% coinsurance	6 months
Prosthodontics • Dentures • Bridges • Dental Implants (covered)	60% coinsurance	50% coinsurance	6 months
Prosthetic Repairs/Adjustments	60% coinsurance	50% coinsurance	6 months
Orthodontic Services • Dependent children only*	50% coinsurance	50% coinsurance	12 months

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your certificate of coverage. In the event of a discrepancy between the information in this summary and the certificate of coverage, the certificate will prevail.
*Child orthodontic coverage begins at age eight and runs through age 18. This means that the child must have been banded between the ages of eight and 19 in order to receive coverage. If children are dependents until age 19, they can continue to receive coverage, but they must have been banded before age 19.

Anthem BlueCross BlueShield

Emergency dental treatment for the international traveler

As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.** With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem. To learn more about the program, please visit the International Emergency Dental Web site at www.decaredental.com/internationalDentalProgram.do.

Promoting healthy mouths for members who are pregnant or living with diabetes

If you are pregnant or living with diabetes, you can sign up to receive one additional dental cleaning or periodontal maintenance procedure per year.

Finding a dentist is easy.

To select a dentist by name or location, do one of the following:

- Go to anthem.com/mydentalvision
- Call Anthem dental customer service at the toll-free number listed on the back of your ID card.

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Refer to the back of your plan ID card for the address.

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services

Oral evaluations (exam) Limited to two per Calendar Year

Teeth cleaning (prophylaxis) Limited to two per Calendar Year

Intraoral X-rays, single film Limited to four films per 12-month period

Complete series X-rays (panoramic or full-mouth) Limited to once every five years

Topical fluoride application Limited to once every 12 months for members through age 18

Sealants Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services.

Basic and/or Major Services***

Fillings Limited to once per surface per tooth in any 24 months

Space Maintainers Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16; space maintainers may be covered under Diagnostic and Preventive or Basic Services.

Crowns Limited to once per tooth in a seven-year period

Fixed or removable prosthodontics – dentures, partials, bridges, tooth implants

Covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.

Root canal therapy Limited to once per lifetime per tooth; coverage is for permanent teeth only.

Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Periodontal scaling and root planing Limited to once per quadrant in 36 months, when the tooth pocket has a depth of four millimeters or greater

Brush biopsy (Not covered)

***Waiting periods** for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan. There may be a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES – *if Orthodontia is included as a benefit of your dental plan*

Orthodontia Limited to one course of treatment per member per lifetime

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage for a full list.

Services provided before or after the term of this coverage Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) Orthodontic braces, appliances and all related services

Cosmetic dentistry Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Extractions Surgical removal of third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Life and Health Insurance Company.

Blue View Vision℠
FS.B.10.20.130.130
MP Benefits Management
Effective: 01/01/2021

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com**, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$10 Copay	Reimbursed Up To $42	Once every calendar year
Eyeglass Frames			
One pair of eyeglass frames	$130 Allowance, then 20% off any remaining balance	Reimbursed Up To $45	Once every other calendar year
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses • Single vision lenses • Bifocal lenses • Trifocal lenses	 $20 Copay $20 Copay $20 Copay	 Reimbursed up to $40 Reimbursed up to $60 Reimbursed up to $80	Once every calendar year
Eyeglass Lens Enhancements *When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost*			
• Transitions Lenses (for a child under age 19) • Standard polycarbonate (for a child under age 19) • Factory Scratch Coating	$0 Copay $0 Copay $0 Copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses *(instead of eyeglass lenses)* *Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.*			
• Elective conventional (non-disposable) OR	$130 Allowance, then 15% off any remaining balance	Reimbursed up to $105	Once every calendar year
• Elective disposable OR	$130 Allowance *(no additional discount)*	Reimbursed up to $105	
• Non-elective (medically necessary)	Covered in full	Reimbursed up to $210	

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-Network Member Cost (after any applicable copay)
Retinal Imaging – at member's option, can be performed a time of eye exam		Not more than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	○ Transitions lenses (Adults)
	○ Standard Polycarbonate (Adults)
	○ Tint (Solid and Gradient)
	○ UV Coating
	○ Progressive Lenses[1]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	  ○ Premium Tier 3
	○ Anti-Reflective Coating[2]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	○ Other Add-ons
		$75
		$40
		$15
		$15
		
		$65
		$85
		$95
		$110
		
		$45
		$57
		$68
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider	○ Complete Pair ○ Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	○ Standard contact lens fitting[3] ○ Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	○ Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available anti-reflective brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where State law prevents discounting of products and services that are not covered benefits under this plan. Discounts on frames will not apply if the manufacturer has imposed a no discount on sales at retail and independent provider locations.

Some of our in-network providers include:

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

Online stores:

GLASSES.COM glasses.com | contactsdirect contactsdirect.com | 1800contacts 1800contacts.com | LENSCRAFTERS lenscrafters.com | OPTICAL targetoptical.com | Ray-Ban ray-ban.com/insurance

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at **anthem.com**, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at **anthem.com**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at 1-866-723-0515 .to request a claim form.

TO FAX: 866-293-7373
TO EMAIL: ooneclaims@eyewearspecialoffers.com
TO MAIL: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

EPIC | SPECIALTY BENEFITS

Underwriting & Administration
www.epicbenefits.com

Managepoint, LLC
Effective Date: January 1, 2021

BASIC GROUP LIFE INSURANCE — SUMMARY OF BENEFITS

Basic Group Life		**Spouse and Dependents**
Eligibility:	Active, full-time employees	
Benefit Amount:	$25,000 **Monthly Rate: $5.25**	$10,000 - Spouse $5,000 - Child(ren) **Monthly Rate: $2.65**
Guarantee Issue:	$25,000	$10,000 - Spouse $5,000 - Child(ren)
Waiver of Premium:	Included prior to age 60.	
Age Reduction:	Reduces at age 65 to 65% and at age 70 to 50% of the face amount.	
Living Benefit Provision:	In the event of terminal illness, insured may elect payment of up to 50% of the life benefit but not more than $12,500.	

AD&D Benefit	
Amount:	Same benefit as life. Coverage is 24 hour, occupational.
Waiver of Premium:	Not applicable.

Managepoint

☐ NEW ENROLLMENT
☐ TERMINATION DATE _____

☐ DATA CHANGE EFFECTIVE DATE _____
Explain, i.e. address, name, beneficiary, newborn

Dental, Vision, & Life
ENROLLMENT FORM

EMPLOYER					
EMPLOYEE'S NAME: LAST	FIRST	INT	SOCIAL SECURTIY #	BIRTH DATE	GENDER
EMPLOYEE'S STREET ADDRESS			CITY	STATE	ZIP

MARITAL STATUS : ☐**SINGLE** ☐**DIVORCED** ☐**WIDOWED** ☐**MARRIED** ☐**LEGALLY SEPARATED**

Epic Life Insurance Company:
***BASIC TERM LIFE AND AD&D** Benefits reduce by the following percents: 35% at age 65; an additional 15% of the original amount at age 70. Benefits terminate at retirement.
****DEPENDENT LIFE: Spouse coverage** terms at Employees Termination. **Child coverage** begins at age 15 days and ends at age 19 or until age 25 if still a federal tax exemption on your taxes.
Dental: See Summary of Benefits

EMPLOYEE BENEFICIARY DESIGNATION (include full proper name and relationship: i.e.: Mary A. Jones, wife.)
SHOULD BE OVER 18 YEARS OF AGE

PRIMARY BENEFICIARY NAME	Percentage **(must add up to 100%)**	RELATIONSHIP
PRIMARY BENEFICIARY NAME	Percentage **(must add up to 100%)**	RELATIONSHIP
CONTINGENT BENEFICIARY		RELATIONSHIP

ENROLLMENT INFORMATION. PLEASE COMPLETE FOR SELF AND EACH DEPENDENT TO BE INSURED
Place an "X" (or specific $ amount requested) under each benefit for each dependent you are requesting coverage.

	NAME (LAST, FIRST, MIDDLE INITIAL)	SEX	BIRTH DATE	SOCIAL SECURITY NUMBER	ANTHEM DENTAL	ANTHEM VISION	*EPIC BASIC LIFE* $25,000	ADDITIONAL LIFE: List amount up to $500,000 Guarantee Issue $100,000	DEPENDENT LIFE:** Spouse $10,000 Children $5,000 each
Employee		☐ **F** ☐ **M**						**Need to complete the Epic enrollment form included in the packet.**	
Spouse		☐ **F** ☐ **M**							
Child 1		☐ **F** ☐ **M**							
Child 2		☐ **F** ☐ **M**							
Child 3		☐ **F** ☐ **M**							
Child 4		☐ **F** ☐ **M**							

Are ☐ You ☐ Your spouse, or ☐ Dependents covered under another plan? If yes, name of plan

Please turn page over for Waiver and Signature

WAIVER OF BENEFITS (Complete only if not enrolling)

I understand that by waiving coverage during my initial enrollment period, I can enroll only within 30 days of a life event such as marriage, divorce, birth, death or spouse termination and loss of coverage or during Open Enrollment. I **have 30 days to submit an enrollment form to Managepoint following a life event**.

I decline the following employee coverage/s available to me:

☐ Anthem Dental ☐ Anthem Vision ☐ Epic Life

My dependents decline the following coverage available to them:

☐ Anthem Dental ☐ Anthem Vision ☐ Epic Dependent Life

I hereby (1) request coverage for the Benefits for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the coverage (3) state that I became an employee on the date stated above, and do currently work the number of hours per week stated above; and (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. Any person who, with intent to defraud or knowing that he is facilitating a fraud against The Plan, submits an application or files a claim containing a false or deceptive statement is guilty of fraud. I understand I am restricted from changes regarding this plan unless a qualified status change has occurred or during Open Enrollment. I have reviewed the statement on this application and they are true and complete.

Employee Signature _____ Date _____

EPIC SPECIALTY BENEFITS

Underwriting & Administration
www.epicbenefits.com

Managepoint

Office: (317) 377-3100
Fax: (317) 549-9119
benefits@managepoint.biz

SUPPLEMENTAL GROUP TERM LIFE OFFERING

GREAT NEWS!

As a new hire with Managepoint LLC, you now have the opportunity to purchase additional Supplemental Group Term Life Insurance through The EPIC Life Insurance Company. Coverage is for **you and your spouse and/or dependents.**

For Yourself: Up to 5 times annual salary, not to exceed combined total $500,000. Guarantee Issue up to $100,000 (no medical questions).
For Your Spouse: Up to 50% of employee elected Supplemental Life amount. Guarantee Issue up to $25,000 (no medical questions).
For Your Eligible Children: $10,000 in coverage for each family unit.

Note: If you were eligible for Supplemental Life during open enrollment or any time prior to 2020 and declined the coverage you will need to go through underwriting for approval of the elected coverage.

Important: Supplemental Life is only available for your spouse and children if YOU, the employee, elect Supplemental Life on yourself.

WHY SHOULD I PURCHASE SUPPLEMENTAL LIFE?

- Group-based product, this means rates are affordable
- Certain coverage levels are available without medical underwriting
- Easy enrollment
- Payments through payroll deduction

TO ENROLL:

Rate Calculation: Go to the Rate Grid on back. Find your AGE band then find your desired insurance amount (in $5,000 increments), this is your monthly rate.

Note: Rates will be deducted through payroll; a biweekly pay period deduction should be approximately half of monthly. If you were eligible for Supplemental Life during Open Enrollment or any time prior to 2021 and declined coverage, you will need to go through underwriting for approval of the elected coverage.

Application: Fill out the highlighted areas of the attached EPIC Employee Application. Please sign the application on the back. Return to Managepoint.

Coverage effective January 1, 2021

MONTHLY SUPPLEMENTAL LIFE PREMIUMS FOR EMPLOYEE, SPOUSE

AGE	Monthly Rate per $1,000	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
<30	0.090	$0.45	$0.90	$1.35	$1.80	$2.25	$2.70	$3.15	$3.60	$4.05	$4.50
30-34	0.090	$0.45	$0.90	$1.35	$1.80	$2.25	$2.70	$3.15	$3.60	$4.05	$4.50
35-39	0.130	$0.65	$1.30	$1.95	$2.60	$3.25	$3.90	$4.55	$5.20	$5.85	$6.50
40-44	0.180	$0.90	$1.80	$2.70	$3.60	$4.50	$5.40	$6.30	$7.20	$8.10	$9.00
45-49	0.270	$1.35	$2.70	$4.05	$5.40	$6.75	$8.10	$9.45	$10.80	$12.15	$13.50
50-54	0.480	$2.40	$4.80	$7.20	$9.60	$12.00	$14.40	$16.80	$19.20	$21.60	$24.00
55-59	0.780	$3.90	$7.80	$11.70	$15.60	$19.50	$23.40	$27.30	$31.20	$35.10	$39.00
60-64	1.050	$5.25	$10.50	$15.75	$21.00	$26.25	$31.50	$36.75	$42.00	$47.25	$52.50
65-69	1.580	$3,250	$6,500	$9,780	$13,000	$16,250	$19,500	$22,750	$26,000	$29,250	$32,500
		$5.14	$10.27	$15.41	$20.54	$25.68	$30.81	$35.95	$41.08	$46.22	$51.35
70-74	2.880	$2,500	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
		$7.20	$14.40	$21.60	$28.80	$36.00	$43.20	$50.40	$57.60	$64.80	$72.00
75-79	4.340	$1,250	$2,500	$3,750	$5,000	$6,250	$7,500	$8,750	$10,000	$11,250	$12,500
		$5.43	$10.85	$16.28	$21.70	$27.13	$32.55	$37.98	$43.40	$48.83	$54.25
80-99	7.890	$1,250	$2,500	$3,750	$5,000	$6,250	$7,500	$8,750	$10,000	$11,250	$12,500
		$9.86	$19.73	$29.59	$39.45	$49.31	$59.18	$69.04	$78.90	$88.76	$98.63

Example: Use this formula to calculate premium for benefit amounts over $50,000

	AGE	Monthly Rate per $1,000	X	Benefit in $1,000's	=	Monthly Cost
Example:	35	.13	X	150	=	$19.50
			X		=	

Dependent Child Supplemental Life Monthly Rate: $10,000 coverage $1.50/family unit

EPIC SPECIALTY BENEFITS

Managepoint

Employee's Application for Group Insurance Coverage

The EPIC Life Insurance Company
1717 W. Broadway
Madison, WI 53713

Instructions: Please complete the entire form in black ink. If you are waiving/declining coverage at this time you are still required to complete Sections 1.,3., and 5.

1. General Information

☐ New Employee ☐ Change ☐ Class 1 ☐ Class 2

Group Name Managepoint LLC Group Number 803633 Requested Effective Date _____

Requested Action ☐ Add Coverage ☐ Term Coverage ☐ Beneficiary Change ☐ Other (describe) _____

Last Name _____ First Name _____ Middle Initial _____

Employee Address _____ City _____ County _____ State _____ Zip _____

Date of Birth _____ Phone Number _____ Social Security Number _____

Employee Email _____ Occupational Title _____ Annual Earnings $ _____

Date of Hire _____ Hrs. Worked/Week _____ Marital Status: ☐ Single ☐ Married Sex: ☐ Male ☐ Female

Have you ever applied for, been insured by, or are currently insured by The EPIC Life Insurance Company? ☐ Yes ☐ No

If yes, provide details: _____

List all family members to be insured including first and last name (For additional space, use separate sheet)	Relationship to Employee	Sex	Birth Date

2. Beneficiary Selection

Primary Beneficiary (if multiple, specify allocation to equal 100%)

Name and Relationship	Date of Birth	Address	% of Benefit

Contingent Beneficiary (optional)

Name and Relationship	Date of Birth	Address	% of Benefit

Consent of Spouse
(To be completed in community property states when the spouse of the insured is not designated as the primary beneficiary)

I understand that by signing below, I consent to the designation of the above person(s) as Primary Beneficiary(ies) and hereby waive any rights I may have to the proceeds of such insurance benefit under applicable community property laws.

Spousal Consent Signature: _____ Date: _____

For Office Use Only	GN	DIV	Class	PP	ED	CC

3. Coverage Selection

Please check the coverage(s) that you are applying for below. Availability of coverage(s) is based on your group's selected plan of insurance.

Coverage Type	Applying For	Waiving/Declining
Term Life/Accidental Death & Dismemberment	☐ Myself	
Dependent Term Life	☐ My Spouse ☐ My Dependents	
Supplemental Term Life/AD&D Employee Guarantee Issue $100,000 Spouse Guarantee Issue $25,000	☐ Myself $_____ or _____ x your annual earnings ☐ My Spouse $_____ ☐ My Dependents	☐ Myself ☐ My Spouse ☐ My Dependents

4. Health Questions

The health questions need to be answered if: (1) your Life/STD/LTD amount applied for is over the guarantee issue amount; or (2) you are not applying within 30 days of completing your probationary period.

1. Within the last five (5) years, have you or any dependent ever had or been treated by a physician or a member of the medical profession for any of the following: heart disorder, high blood pressure, back disorder, stroke, cancer, tumor, diabetes, kidney or liver disease, an immune deficiency disorder, AIDS, AIDS-Related Complex (ARC), respiratory, or any mental or nervous system disorder? AIDS testing received at anonymous counseling and testing sites or through a home test kit need not be revealed. We are not seeking the results of HIV antibody tests. ☐ Yes ☐ No
2. Within the last seven (7) years, have you or any dependent ever been treated for, arrested in connection with, or been told to have counseling for the use of alcohol or drugs? ☐ Yes ☐ No
3. Within the last five (5) years have you or any dependent received treatment from and/or consulted a physician, psychiatrist, psychologist, or other medical practitioner or taken prescription medication? ☐ Yes ☐ No
4. Have you or any dependents ever had life/disability insurance rejected, rated, or restricted? ☐ Yes ☐ No
5. Employee: Height _____ Weight _____ Spouse: Height _____ Weight _____

GIVE COMPLETE DETAILS FOR EVERY "YES" RESPONSE TO QUESTIONS 1 - 4 (For additional space, use separate sheet)

Question No.	Name of Person Treated and Full information as to Nature of Ailment	Date Of Onset	Last Date Seen for this Condition	Recovery Status	Treatment Given	Complete Name, Address, and Phone Number of Attending Physician

5. Agreement Authorization

I hereby request coverage for the group benefit(s) selected above in Section 3. I authorize my employer to take deductions from my pay if contributions are required for the coverage elected.

CERTIFICATION: I represent and certify all of the following: (1) I am employed by the employer named herein and am working the number of hours indicated in Section 1. above; (2) I have read and completed this entire application by myself, and that no other person, including the agent, completed any portion of this application; (3) I entered each and every answer myself in response to each request for information and/or question; (4) no answer or information written by myself in this application was provided by the agent or anyone else (except for information provided by other family members); (5) such representations are true, accurate, and complete to the best of my knowledge; (6) I, and my spouse and dependent(s), have been given the opportunity to apply for the coverage(s) available to me (us) through my employer; and (7) and I was neither pressured nor forced by my employer, the agent, or EPIC into waiving/declining any coverage as shown in Section 3.

UNDERSTANDING: I understand: (1) the representations I make, together with any supplemental representations that I make, shall be the basis for EPIC to determine eligibility for issuing coverage; (2) that no person, except the President & CEO or Chief Operating Officer of EPIC, has the authority to: (a) determine whether any contract (s) of insurance shall be used on the basis of the application;(b) waive or modify any of the provisions of the application or any of EPIC's requirements or rights; (c) bind EPIC by any statement or promise pertaining to any insurance contract (s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained on the written application (3) that no coverage will be effective unless and until the date specified by EPIC after this application has been approved by EPIC; (4) any misrepresentation contained herein may be used to reduce or deny a claim, void coverage, or void the group contract(s) within the contestable period, if such misrepresentation materially affects EPIC's acceptance of the risk; including approving any person for coverage; (5) if I decline any coverage, future changes in coverage are NOT automatic and will be subject to EPIC approval; and (6) if my death occurs before EPIC has approved in writing any EPIC coverage, the only death benefit provided shall be the lesser of the maximum amount available without evidence of insurability or the maximum amount I am eligible for, under the coverage(s) for which I was eligible.

I understand that EPIC is not liable for any statement, representation, or other information provided to myself, my spouse or my dependent(s) that is not expressly contained in a written document provided to them and signed by an EPIC authorized executive officer.

I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false and deceptive statement is committing a fraudulent act, which is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

5. Agreement Authorization

I understand that EPIC fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, EPIC may rescind and void any coverage if it determines that the employer, a covered employee, or a covered employee's spouse or named dependent, are either listed on the SDN list or associated with an entity listed on the SDN list.

If any payroll deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice to the employer. An Application should not be submitted more than 45 days prior to the effective date. This document will become a part of the insurance contract when coverage is approved and issued.

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me or my minor children to give to EPIC or its legal representative, reinsurers, authorized agents or designees, any and all information (including information that constitutes protected health information as defined in the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA Privacy Regulations"), but excluding psychotherapy notes, if any, in any form, including, but not limited to, in original, electronic, or photographic copies, about me or my minor children to be covered concerning diagnosis, treatment, and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including, but not limited to, all medical and health care records. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV or the results of such a test, if obtained by the individual.

I understand the information obtained by this authorization will be used by EPIC to determine eligibility for coverage under my employer's group policy(ies) and that my failure to authorize the release of said information may result in a refusal to issue or provide coverage. I agree that EPIC may release said information to MIB or to EPIC's reinsuring companies, representative, or other person performing business or legal services in connection with this application or as may be permitted or required by law, or as I may further authorize from time to time.

I understand I may revoke this authorization by providing advance written notice of termination to EPIC at its office in Madison, Wisconsin, and that any information released in reliance on this authorization and prior to such revocation cannot be retrieved. In such case, EPIC, its directors, officers, employees, and agents shall not be held responsible or liable for such release. I understand this authorization will remain valid for 2 years from the date I execute this authorization unless this authorization is revoked by me in writing prior to the end of that 2 year period.

I understand that I am entitled to receive a copy of this completed, signed authorization, and that a photographic copy shall be as valid as the original. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by the HIPAA Privacy Regulations and could be re-disclosed by the person or entity that receives it.

Has any person assisted you in the completion of this form? ☐ Yes ☐ No If yes, please print name: _____

Applicant's Signature _____ Date Signed: _____

Spouse's Signature* _____ Date signed: _____

* Required only if medical questions for spouse need to be answered

Managepoint

FLEXIBLE SPENDING ACCOUNT / HEALTH SAVINGS ACCOUNT
Plan Year 2021

EMPLOYEE INFORMATION:

Employer: _____

Social Security # _____ - _____ - _____ Date of Birth _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____

EMPLOYEE ELECTIONS:

Flexible Spending Account (FSA)	Annual Amount	**OR**	Per Pay Amount
☐ Health FSA (max. $2750/year)	$_____		$_____
☐ Dependent Care FSA (Daycare) (max. $5000/year)	$_____		$_____

Health Savings Account (HSA)- Can only be elected with a High Deductible Medical Plan

☐ Health HSA (max. $3600 Individual / $7200 Family/year) (a catch-up contribution allowed over 55 of $1000)	$_____	$_____

IF YOU CURRENTLY HAVE AN H.S.A. BANK ACCOUNT AND WANT TO USE IT PLEASE PROVIDE THE:

Routing #: _____

Account #: _____

☐ **Savings Account** ☐ **Checking Account**

☐ NO, I do not want to enroll.

☐ YES, I do want to enroll. The IRS regulations state four conditions: 1) Any expenses you incur must be within the plan year; 2) Any expenses you incur must not be covered by any other source, such as insurance; 3) You must provide proper documentation to receive payment; 4) You cannot change or revoke your elections during the plan year unless there is a specific change in status and your employer allows such changes.

Employee Signature: _____ Date: _____

Please fax to Managepoint (317) 543-2020 or (800) 337-1807 – Attn: Benefits

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FOR OFFICE USE ONLY

DOH: _____ Plan Effective Date: _____ Date of 1st Payroll Deduction: _____

Reimbursement Account Options:
Health FSA, Dependent Care Account and HSA

Managepoint has three great reimbursement account options that can reduce your taxable income while allowing you to pay for eligible medical expenses and/or dependent care. The first two options are a **Health Flexible Spending Account (Health FSA)** and a **Dependent Care Account,** which are both under Section 125. Both are administered for Managepoint by eflexgroup.com. The FSA and Dependent Care Account are available to both full-time and part-time employees. Both accounts work the same in that you determine your goal amount for the calendar year, up to a maximum of $2750 for medical and $5000 for dependent care account. Your goal amount is then divided by the number of pays you have remaining in the year, and this amount will be deducted pre-tax from each paycheck you receive. Section 125 guidelines designate that these deductions must continue for the remainder of the year in order to reach your goal amount. IRS regulations prohibit changing this deduction during the year unless you experience a qualified change in family status (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment, loss of coverage, etc.) The change in coverage must be on account of and consistent with the change in family status. Prior to the end of the year, you will have the opportunity to enroll for the upcoming calendar year. *This benefit does not carry over from one year to the next.*

Health Flexible Spending Account (FSA): The goal amount you select is available for reimbursement of eligible medical expenses incurred in the same calendar year. You will receive an EFLEX debit card to pay for such items as office co-pays, prescriptions, dental and vision expenses. A more comprehensive list can be found at www.eflexgroup.com. You may also submit claims for reimbursement online or by completing a reimbursement form and sending the appropriate documentation by fax or mail to eflexgroup.com.

Dependent Care Account: Funds that have been deducted from your paycheck and applied to your account are available for reimbursement for eligible dependent care. Some examples of eligible expenses are day care centers, elder care, preschool, and after school care among others. Options for reimbursement are the same as those described with the Health FSA

Both the Health FSA and the Dependent Care Account have a "Use it or Lose it" clause. IRS rules do not allow unused money in your accounts to be returned to you at the end of the year. Because of this, you want to appropriately estimate your expenses for the year. The plan year runs from January 1st through December 31st each year, and eligible expenses incurred during the plan year will be reimbursed through March 31st of the following year. Any unused money will be forfeited after all eligible claims have been paid. You should confirm that such expenses are eligible by consulting your tax advisor and/or reviewing IRS Publication 502 (health) and Publication 503 (dependent care). Neither your employer, Managepoint, nor eflexgroup.com may expand the list of eligible expenses described in these IRS publications. It should also be noted that the IRS prohibits you from transferring money between a Dependent Care Account and a Health FSA. Additional rules apply under applicable law. These rules are further described in the plan document on file at Managepoint.

Health Savings Account (HSA) is the third reimbursement account option, which is administered for Managepoint by HSA Bank. The HSA is similar to the Health FSA in that you receive pre-tax deductions from each paycheck that go into a special account for eligible medical expenses. You can also receive these deductions post-tax if desired. *One big difference is that only those employees participating in a High Deductible Health Plan (HDHP) are eligible for this account.* A second difference with the HSA is that only the accumulated funds are available for withdrawal. In other words, only the amount of money that has been deducted from your check and applied to the account is available for use. Another difference in the HSA is that you don't forfeit unused money at the end of each year. Rather, any unused balances at the end of the year will rollover for use the next year. Plus, after age 59 and 1/2, unused HSA funds may be withdrawn for non-medical reasons without penalty! (Standard income tax applies.) The account comes with a free debit card and/or you can purchase checks to use for eligible medical expenses. You may also file for reimbursement by submitting the proper claim form and documentation.

There are a few stipulations with the HSA that should be noted:

1. You must be enrolled in a qualifying HDHP to participate.
2. You cannot be covered under any other health plan other than the HDHP.
3. You cannot be enrolled in Medicare.
4. You cannot be claimed as a dependent on another person's tax return.
5. You cannot be enrolled in both a Health FSA and an HSA. You can however, be enrolled in the Dependent Care Account and an HSA.

Contribution limits for the HSA may vary from year to year. For 2021 the Individual maximum is $3600, and the Family maximum is $7200.

Individuals age 55 or older who are not enrolled in Medicare may contribute more to the account per year. In 2021, an additional $1,000 contribution will be allowed.

If you would like additional information on any of the three reimbursement accounts listed above, please refer to the eflexgroup.com and HSA Bank brochures included with this packet or contact Managepoint.

Important update regarding FSA, HRA, and HSA eligibility of Over-the-Counter (OTC) Medicines and Drugs. This legislation affects the eligibility and reimbursement of OTC MEDICATIONS OR DRUGS ONLY. It does not affect medications that legally require a prescription to be dispensed (including co-pay prescriptions) or over-the-counter items that do not fall in the medicines or drug category, such as bandages, crutches, etc. A Doctor's Prescription is Required for Reimbursement of OTC Medicines or Drugs. A Letter of Medical Necessity is no longer an acceptable form of substantiation for over-the-counter medications or drugs, such as aspirin or cough syrup, that are used to treat a medical condition.

financial center
Your Indiana Credit Union

Health Savings Account (HSA)

Membership Eligibility: *Counties of Eligibility are Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Marion (Townships: Center, Franklin, Lawrence, Perry, Pike, Washington, Warren, or Wayne), Morgan, Putnam or Shelby County, Indiana*

❑ Live or Work
County and Township
_____
Only Marion County MUST specify Township

❑ Family Member
Name:_____
Relationship:_____
Spouse, parent/step parent, child/step child, sibling/step sibling, grandparent, grandchild, aunt/uncle, or niece/nephew

❑ Employer Group
Employer:_____
www.fcfcu.com/eligibility

Member Information:

Account Number:_____
Full Name:_____ Mother's Maiden Name:_____
Address:_____
Driver's License # ID:_____ ID Expiration Date:_____ ID State of Issuance_____
Employer:_____

Debit Card Requested for Member ❑ Yes
May we share information with our third party partners to provide you special offers? ❑ Yes ❑ No

Type of Insurance Plan

❑ Family ❑ Individual

Authorized Signers - Ability to make account inquiries and may have debit card upon request. Not allowed to make account changes.

Name:_____ Social Security #:_____ Date of Birth:_____
Name:_____ Social Security #:_____ Date of Birth:_____
Name:_____ Social Security #:_____ Date of Birth:_____

By signing below, the undersigned apply for membership with Financial Center First Credit Union (aka Financial Center); and agree to its bylaws and terms and conditions of any approved account(s), as amended from time to time. I/We will notify the Credit Union of any material change to this information. Signature below also acknowledges receipt of the Account Agreements and Disclosures applicable to the accounts and services requested above. I/We agree to be bound by the terms and conditions of the Account Agreements and Disclosures.
Everything that I/we have stated in this application is correct to the best of my/our knowledge. The Credit Union is authorized to check my/our credit, employment history, obtain a credit report and to answer questions about its credit experience with me/us. I/We expressly authorize any person, firm, corporation, association, personnel office or Commanding Officer to provide my/our current address or other information concerning me/us relevant to the review and evaluation of this application or subsequent application for membership and/or credit. I/We understand that it may be a federal crime punishable by fine or imprisonment, or both, to knowingly make any false statement concerning any of the above facts as applicable under the provision of the United States Criminal Code.

Tax Identification Number and Backup Withholding Information

Under penalties of perjury, I certify that: 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. Person (including a U.S. resident alien).
Certification instructions.

☐ If you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return please mark the box.

"The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding."

By signing below you authorize Financial Center First Credit Union to ADD or REMOVE the above individual(s) as authorized users to your Health Savings Account and issue/revoke a Health Savings Account Debit Card. You agree to the terms and conditions of the Important Account Information Brochure, the Credit Union HSA Disclosure Statement and the Financial Center First Credit Union debit cardholder agreement that was provided at account opening. Authorized user debit card(s) will be mailed to the Primary Applicant's home address.

Member Signature:_____ Date:_____

By signing below you give us permission to share necessary account information with the employer listed above to ensure accurate processing of both employer and/or employee contributions to this HSA account.

Member Signature:_____ Date:_____

Internal Use Only

Membership Officer:_____ Date:_____ Center #:_____ Teller #:_____ REV 01/15

HSA Simplifier®

HEALTH SAVINGS ACCOUNT APPLICATION

PART 1. HSA OWNER

Name *(First/MI/Last)* _____

Address Line 1 _____

Address Line 2 _____

City/State/ZIP _____

Social Security Number _____

Date of Birth _____ Phone _____

Email Address _____

Account Number _____

PART 2. HSA TRUSTEE

To be completed by the HSA trustee

Name Financial Center First Credit Union

Address Line 1 7101 E. 56th St.

Address Line 2 _____

City/State/ZIP Indianapolis, IN 46226

Phone (317) 916-7700 Organization Number _____

☐ *This is an amendment to an existing HSA.*

☐ *This HSA contains managed investments as described in the Trustee Management of Investment section of the agreement.*

PART 3. CONTRIBUTION INFORMATION

Contribution Amount _____ Contribution Date _____

CONTRIBUTION TYPE *(Select one)*

☐ **1. Regular** *(Includes catch-up contributions as well as qualified HSA funding distributions from an IRA)*

Contribution for Tax Year _____ *(Qualified HSA funding distributions from an IRA must be made for the current tax year)*

☐ **2. Rollover** *(Distribution from an HSA or Archer MSA that is being deposited into this HSA)*

By selecting this transaction, I irrevocably designate this contribution as a rollover.

☐ **3. Transfer** *(Direct movement of assets from an HSA or Archer MSA into this HSA)*

PART 4. INVESTMENT AND DEPOSIT INFORMATION

INVESTMENT INFORMATION *(Complete this section as applicable.)*

Investment Description	Quantity or Amount	Investment Number	Term or Maturity Date	Interest Rate

DEPOSIT METHOD

☐ **Cash or Check** *(If the contribution type is transfer, the check must be from a financial organization made payable to the trustee for this HSA.)*

☐ **Internal Account**

Account Number _____ Type *(e.g., checking, savings, HSA)* _____

☐ **External Account** *(e.g., EFT, ACH, wire)*

Name of Organization Sending the Assets _____ Routing Number *(optional)* _____

Account Number _____ Type *(e.g., checking, savings, HSA)* _____

Deposit Taken by _____

PART 5. BENEFICIARY DESIGNATION

I designate that upon my death, the assets in this account be paid to the beneficiaries named below. The interest of any beneficiary that predeceases me terminates completely, and the percentage share of any remaining beneficiaries will be increased on a pro rata basis. If no beneficiaries are named, my estate will be my beneficiary.

☐ I elect not to designate beneficiaries at this time and understand that I may designate beneficiaries at a later date.

PRIMARY BENEFICIARIES *(The total percentage designated must equal 100%.)*

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

CONTINGENT BENEFICIARIES *(The total percentage designated must equal 100%.) (The balance in the account will be payable to these beneficiaries if all primary beneficiaries have predeceased the HSA owner.)*

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

☐ *Check here if additional beneficiaries are listed on an attached addendum.* Total number of addendums attached to this HSA _____

PART 6. SPOUSAL CONSENT

Spousal consent should be considered if either the trust or the residence of the HSA owner is located in a community or marital property state.

CURRENT MARITAL STATUS

☐ **I Am Not Married –** I understand that if I become married in the future, I should review the requirements for spousal consent.

☐ **I Am Married –** I understand that if I choose to designate a primary beneficiary other than or in addition to my spouse, my spouse should sign below.

CONSENT OF SPOUSE

I am the spouse of the above-named HSA owner. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Because of the important tax consequences of giving up my interest in this HSA, I have been advised to see a tax professional.

I hereby give the HSA owner my interest in the assets or property deposited in this HSA and consent to the beneficiary designation indicated above. I assume full responsibility for any adverse consequences that may result.

X _____ _____
Signature of Spouse — Date *(mm/dd/yyyy)*

X _____ _____
Signature of Witness — Date *(mm/dd/yyyy)*

PART 7. SIGNATURES

Important: *Please read before signing.*

I understand the eligibility requirements for the type of HSA deposit I am making, and I state that I do qualify to make the deposit. I have received a copy of the Health Savings Account Application, the 5305-B Trust Account Agreement, and the Disclosure Statement. I understand that the terms and conditions that apply to this HSA are contained in this Application and the HSA Trust Account Agreement. I agree to be bound by those terms and conditions.

I assume complete responsibility for

- determining that I am eligible for an HSA each year I make a contribution,
- ensuring that all contributions I make are within the limits set forth by the tax laws, and
- the tax consequences of any contributions (including rollover contributions) and distributions.

X _____ _____
Signature of HSA Owner — Date *(mm/dd/yyyy)*

X _____ _____
Signature of Witness — Date *(mm/dd/yyyy)*

X _____ _____
Signature of Trustee — Date *(mm/dd/yyyy)*

HEALTH SAVINGS TRUST ACCOUNT AGREEMENT

Form 5305-B under section 223(a) of the Internal Revenue Code. FORM (December 2011)

The account owner named on the application is establishing this health savings account (HSA) exclusively for the purpose of paying or reimbursing qualified medical expenses of the account owner, his or her spouse, and dependents. The account owner represents that, unless this account is used solely to make rollover contributions, he or she is eligible to contribute to this HSA; specifically, that he or she: (1) is covered under a high deductible health plan (HDHP), (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage), (3) is not enrolled in Medicare, and (4) cannot be claimed as a dependent on another person's tax return.

The account owner has assigned the trust account the sum indicated on the application.

The account owner and the trustee make the following agreement:

ARTICLE I

1. The trustee will accept additional cash contributions for the tax year made by the account owner or on behalf of the account owner (by an employer, family member, or any other person). No contributions will be accepted by the trustee for any account owner that exceeds the maximum amount for family coverage plus the catch-up contribution.
2. Contributions for any tax year may be made at any time before the deadline for filing the account owner's federal income tax return for that year (without extensions).
3. Rollover contributions from an HSA or an Archer medical savings account (Archer MSA) (unless prohibited under this agreement) need not be in cash and are not subject to the maximum annual contribution limit set forth in Article II.
4. Qualified HSA distributions from a health flexible spending arrangement or health reimbursement arrangement must be completed in a trustee-to-trustee transfer and are not subject to the maximum annual contribution limit set forth in Article II.
5. Qualified HSA funding distributions from an individual retirement account must be completed in a trustee-to-trustee transfer and are subject to the maximum annual contribution limit set forth in Article II.

ARTICLE II

1. For calendar year 2011, the maximum annual contribution limit for an account owner with single coverage is $3,050. This amount increases to $3,100 in 2012. For calendar year 2011, the maximum annual contribution limit for an account owner with family coverage is $6,150. This amount increases to $6,250 in 2012. These limits are subject to cost-of-living adjustments after 2012.
2. Contributions to Archer MSAs or other HSAs count toward the maximum annual contribution limit to this HSA.
3. For calendar year 2009 and later years, an additional $1,000 catch-up contribution may be made for an account owner who is at least age 55 or older and not enrolled in Medicare.
4. Contributions in excess of the maximum annual contribution limit are subject to an excise tax. However, the catch-up contributions are not subject to an excise tax.

ARTICLE III

It is the responsibility of the account owner to determine whether contributions to this HSA have exceeded the maximum annual contribution limit described in Article II. If contributions to this HSA exceed the maximum annual contribution limit, the account owner shall notify the trustee that there exist excess contributions to the HSA. It is the responsibility of the account owner to request the withdrawal of the excess contribution and any net income attributable to such excess contribution.

ARTICLE IV

The account owner's interest in the balance in this trust account is nonforfeitable.

ARTICLE V

1. No part of the trust funds in this account may be invested in life insurance contracts or in collectibles as defined in section 408(m).
2. The assets of this account may not be commingled with other property except in a common trust fund or common investment fund.
3. Neither the account owner nor the trustee will engage in any prohibited transaction with respect to this account (such as borrowing or pledging the account or engaging in any other prohibited transaction as defined in section 4975).

ARTICLE VI

1. Distributions of funds from this HSA may be made upon the direction of the account owner.
2. Distributions from this HSA that are used exclusively to pay or reimburse qualified medical expenses of the account owner, his or her spouse, or dependents are tax-free. However, distributions that are not used for qualified medical expenses are included in the account owner's gross income and are subject to an additional 20 percent tax on that amount. The additional 20 percent tax does not apply if the distribution is made after the account owner's death, disability, or reaching age 65.
3. The trustee is not required to determine whether the distribution is for the payment or reimbursement of qualified medical expenses. Only the account owner is responsible for substantiating that the distribution is for qualified medical expenses and must maintain records sufficient to show, if required, that the distribution is tax-free.

ARTICLE VII

If the account owner dies before the entire interest in the account is distributed, the entire account will be disposed of as follows:

1. If the beneficiary is the account owner's spouse, the HSA will become the spouse's HSA as of the date of death.
2. If the beneficiary is not the account owner's spouse, the HSA will cease to be an HSA as of the date of death. If the beneficiary is the account owner's estate, the fair market value of the account as of the date of death is taxable on the account owner's final return. For other beneficiaries, the fair market value of the account is taxable to that person in the tax year that includes such date.

ARTICLE VIII

1. The account owner agrees to provide the trustee with information necessary for the trustee to prepare any report or return required by the IRS.
2. The trustee agrees to prepare and submit any report or return as prescribed by the IRS.

ARTICLE IX

Notwithstanding any other article that may be added or incorporated in this agreement, the provisions of Articles I through VIII and this sentence are controlling. Any additional article in this agreement that is inconsistent with section 223 or IRS published guidance will be void.

ARTICLE X

This agreement will be amended from time to time to comply with the provisions of the Code or IRS published guidance. Other amendments may be made with the consent of the persons whose signatures appear on the application.

ARTICLE XI

11.01 **Definitions –** In this part of this agreement (Article XI), the words "you" and "your" mean the account owner. The words "we," "us," and "our" mean the trustee. The word "Code" means the Internal Revenue Code, and "regulations" means the Treasury regulations.

11.02 **Notices and Change of Address –** Any required notice regarding this HSA will be considered effective when we send it to the intended recipient at the last address that we have in our records. Any notice to be given to us will be considered effective when we actually receive it. You, or the intended recipient, must notify us of any change of address.

11.03 **Representations and Responsibilities –** You represent and warrant to us that any information you have given or will give us with respect to this agreement is complete and accurate. Further, you agree that any directions you give us or action you take will be proper under this agreement, and that we are entitled to rely upon any such information or directions. If we fail to receive directions from you regarding any transaction, if we receive ambiguous directions regarding any transaction, or if we, in good faith, believe that any transaction requested is in dispute, we reserve the right to take no action until further clarification acceptable to us is received from you or the appropriate government or judicial authority. We will not be responsible for losses of any kind that may result from your directions to us or your actions or failures to act, and you agree to reimburse us for any loss we may incur as a result of such directions, actions, or failures to act. We will not be responsible for any penalties, taxes, judgments, or expenses you incur in connection with your HSA. We have no duty to determine whether your contributions or distributions comply with the Code, regulations, rulings, or this agreement. We have the right to require you to provide, on a form provided by or acceptable to us, proof or certification that you are eligible to contribute to this HSA, including, but not limited to, proof or certification that you are covered by an HDHP. In no event will we be responsible to determine if contributions made by your employer to your HSA meet the requirements for comparable contributions, the rules of which are set forth in the Code and IRS published guidance.

We may permit you to appoint, through written notice acceptable to us, an authorized agent to act on your behalf with respect to this agreement (e.g., attorney-in-fact, executor, administrator, investment manager), but we have no duty to determine the validity of such appointment or any instrument appointing such authorized agent. In addition, we may allow you to designate an authorized signer to perform various limited transactions on your HSA as specified in a form provided by or acceptable to us. We may rely upon this designation until such time, if any, that we receive a written revocation of the authorization. We will not be responsible for losses of any kind that may result from directions, actions, or failures to act by your authorized agent and/or authorized signer, and you agree to reimburse us for any loss we may incur as a result of such directions, actions, or failures to act by your authorized agent and/or authorized signer.

You will have 60 days after you receive any documents, statements, or other information from us to notify us in writing of any errors or inaccuracies reflected in these documents, statements, or other information. If you do not notify us within 60 days, the documents, statements, or other information will be deemed correct and accurate, and we will have no further liability or obligation for such documents, statements, other information, or the transactions described therein.

By performing services under this agreement, we are acting as your agent. Unless section 11.06(b) of this agreement applies, you acknowledge and agree that nothing in this agreement will be construed as conferring fiduciary status upon us. We will not be required to perform any additional services unless specifically agreed to under the terms and conditions of this agreement, or as required under the Code and the regulations promulgated thereunder with respect to HSAs. You agree to indemnify and hold us harmless for any and all claims, actions, proceedings, damages, judgments, liabilities, costs, and expenses, including attorney's fees arising from or in connection with this agreement.

To the extent written instructions or notices are required under this agreement, we may accept or provide such information in any other form permitted by the Code or applicable regulations including, but not limited to, electronic communication.

11.04 **Disclosure of Account Information –** We may use agents and/or subcontractors to assist in administering your HSA. We may release nonpublic personal information regarding your HSA to such providers as necessary to provide the products and services made available under this agreement, and to evaluate our business operations and analyze potential product, service, or process improvements.

11.05 **Service Fees –** We have the right to charge an annual service fee or other designated fees (e.g., a transfer, rollover, or termination fee) for maintaining your HSA. In addition, we have the right to be reimbursed for all reasonable expenses, including legal expenses, we incur in connection with the administration of your HSA. We may charge you separately for any fees or expenses, or we may deduct the amount of the fees or expenses from the assets in your HSA at our discretion. We reserve the right to charge any additional fee after giving you 30 days' notice. Fees such as subtransfer agent fees or commissions may be paid to us by third parties for assistance in performing certain transactions with respect to this HSA.

Any brokerage commissions attributable to the assets in your HSA will be charged to your HSA. You cannot reimburse your HSA for those commissions.

11.06 **Investment of Amounts in the HSA –**

a. **Grantor Management of Investment.** Unless the HSA or a portion of the HSA is a managed HSA, you have exclusive responsibility for and control over the investment of the assets of your HSA. All transactions will be subject to any and all restrictions or limitations, direct or indirect, that are imposed by our charter, articles of incorporation, or bylaws; any and all applicable federal and state laws and regulations; the rules, regulations, customs, and usages of any exchange, market, or clearinghouse where the transaction is executed; our policies and practices; and this agreement. We will have no discretion to direct any investment in your HSA. We assume no responsibility for rendering investment advice with respect to your HSA, nor will we offer any opinion or judgment to you on matters concerning the value or suitability of any investment or proposed investment for your HSA. In the absence of instructions from you, or if your instructions are not in a form acceptable to us, we will have the right to hold any uninvested amounts in cash, and we will have no responsibility to invest uninvested cash unless and until directed by you. We will not exercise the voting rights and other shareholder rights with respect to investments in your HSA unless you provide timely written directions acceptable to us.

You will select the investment for your HSA assets from those investments that we are authorized by our charter, articles of incorporation, or bylaws to offer and do in fact offer for HSAs (e.g., term share accounts, passbook accounts, certificates of deposit, money market accounts). We may, in our sole discretion, make available to you, additional investment offerings, that will be limited to publicly-traded securities, mutual funds, money market instruments, and other investments that are obtainable by us and that we are capable of holding in the ordinary course of our business.

b. **Trustee Management of Investment.** If any portion of this HSA is a managed HSA, as indicated on the application or any other supporting documentation, we will manage the investment of the applicable HSA assets. Accordingly, we can manage, sell, contract to sell, grant, or exercise options to purchase, convey, exchange, transfer, abandon, improve, repair, insure, lease for any term, and otherwise deal with all property, real or personal, in your HSA in such manner, for such prices, and on such terms and conditions as we will decide.

We will have the power to do any of the following as we deem necessary or advisable.

1. To invest your HSA assets in a single trust fund, and to collect the income without distinction between principal and income
2. To invest your HSA assets in a common trust fund or common investment fund within the meaning of Code section 223(d)(1)(D)
3. To invest your HSA assets into savings instruments that we offer
4. To invest your HSA assets in any other type of investment permitted by law, including, but not limited to, common or preferred stock, open- or closed-end mutual funds, bonds, notes, debentures, options, U.S. Treasury bills, commercial paper, or real estate
5. To hold any securities or other property under this agreement in our own name, in the name of a nominee, or in bearer form
6. To make, execute, acknowledge, and deliver any and all documents of transfer and conveyance (including documents for the transfer and conveyance of real estate), and any and all instruments that may be necessary or appropriate to carry out our powers
7. To employ suitable agents, attorneys, or other persons
8. To enter into lawsuits or settle any claims concerning the assets in your HSA, and to be reimbursed for any expenses or damages from you or your HSA assets
9. To exercise the voting rights and other shareholder rights with respect to securities in your HSA, provided, however, that we reserve the right to enter into a separate agreement with you governing the exercise of voting and other shareholder rights
10. To perform any and all acts that we deem necessary or appropriate for the proper administration of your HSA

All of the foregoing notwithstanding, our powers will be subject to any and all restrictions or limitations, direct or indirect, that are imposed by our charter, articles of incorporation, or bylaws; any and all applicable federal and state laws and regulations; the rules, regulations, customs, and usages of any exchange, market, or clearing house where the transaction is executed; our policies and practices; and this agreement.

11.07 **Beneficiaries –** If you die before you receive all of the amounts in your HSA, payments from your HSA will be made to your beneficiaries. We have no obligation to pay to your beneficiaries until such time we are notified of your death by receiving a valid death certificate.

You may designate one or more persons or entities as beneficiary of your HSA. This designation can only be made on a form provided by or acceptable to us, and it will only be effective when it is filed with us during your lifetime. Each beneficiary designation you file with us will cancel all previous designations. The consent of your beneficiaries will not be required for you to revoke a beneficiary designation. If you have designated both primary and contingent beneficiaries and no primary beneficiary survives you, the contingent beneficiaries will acquire the designated share of your HSA. If you do not designate a beneficiary or if all of your primary and contingent beneficiaries predecease you, your estate will be the beneficiary.

If your surviving spouse acquires the interest in this HSA by reason of being the beneficiary at your death, this HSA (or in accordance with rules established by the IRS, the relevant portion thereof) will be treated as if the surviving spouse is the account owner.

If the beneficiary is not your spouse, the HSA (or in accordance with rules established by the IRS, the relevant portion thereof) will cease to be an HSA as of the date of your death.

Upon learning of your death, we may, in our complete and sole discretion, make a final distribution to a beneficiary (other than your spouse) of his or her interest in the HSA. This distribution may be made without the beneficiary's consent and may be placed in an interest-bearing (or similar) account that we choose.

11.08 **Termination of Agreement, Resignation, or Removal of Trustee –** Either party may terminate this agreement at any time by giving written notice to the other. We can resign as trustee at any time effective 30 days after we send written notice of our resignation to you. Upon receipt of that notice, you must make arrangements to transfer your HSA to another financial organization. If you do not complete a transfer of your HSA within 30 days from the date we send the notice to you, we have the right to transfer your HSA assets to a successor HSA trustee or custodian that we choose in our sole discretion, or we may pay your HSA to you in a single sum. We will not be liable for any actions or failures to act on the part of any successor trustee or custodian, nor for any tax consequences you may incur that result from the transfer or distribution of your assets pursuant to this section.

If this agreement is terminated, we may charge to your HSA a reasonable amount of money that we believe is necessary to cover any associated costs, including but not limited to, one or more of the following.

- Any fees, expenses, or taxes chargeable against your HSA
- Any penalties or surrender charges associated with the early withdrawal of any savings instrument or other investment in your HSA

If we are a nonbank trustee required to comply with Regulations section 1.408-2(e) and we fail to do so or we are not keeping the records, making the returns, or sending the statements as are required by forms or regulations, the IRS may require us to substitute another trustee or custodian.

We may establish a policy requiring distribution of the entire balance of your HSA to you in cash or property if the balance of your HSA drops below the minimum balance required under the applicable investment or policy established.

11.09 **Successor Trustee –** If our organization changes its name, reorganizes, merges with another organization (or comes under the control of any federal or state agency), or if our entire organization (or any portion that includes your HSA) is bought by another organization, that organization (or agency) will automatically become the trustee or custodian of your HSA, but only if it is the type of organization authorized to serve as an HSA trustee or custodian.

11.10 **Amendments –** We have the right to amend this agreement at any time. Any amendment we make to comply with the Code and related regulations does not require your consent. You will be deemed to have consented to any other amendment, unless within 30 days from the date we send the amendment, you notify us in writing that you do not consent.

11.11 **Withdrawals or Transfers –** All requests for withdrawal or transfer will be in writing on a form provided by or acceptable to us. The method of distribution must be specified in writing or in any other method acceptable to us. The tax identification number of the recipient must be provided to us before we are obligated to make a distribution. Withdrawals will be subject to all applicable tax and other laws and regulations, including but not limited to possible early distribution penalty taxes, surrender charges, and withholding requirements.

We may allow the return of mistaken distributions if there is clear and convincing evidence that the amounts distributed from the HSA were because of a mistake of fact due to reasonable cause. In determining whether this standard has been met, we may rely on your representation that the distribution was, in fact, a mistake.

In no event will we restrict HSA distributions to pay or reimburse only your qualified medical expenses. We may, however, on a case-by-case basis or as a matter of policy, place reasonable restrictions on both the frequency and the minimum amount of distributions from the HSA.

We may establish a policy whereby having a zero balance in your HSA may not cause the HSA to be closed. At our discretion, future contributions may be made to the HSA until you instruct us to close the HSA.

11.12 **Transfers from Other Plans –** We can receive amounts transferred to this HSA from the trustee or custodian of another HSA. In addition, we can accept rollovers of an eligible amount from an Archer MSA. We reserve the right not to accept any transfer or rollover.

11.13 **Liquidation of Assets –** We have the right to liquidate assets in your HSA if necessary to make distributions or to pay fees, expenses, taxes, penalties, or surrender charges properly chargeable against your HSA. If you fail to direct us as to which assets to liquidate, we will decide, in our complete and sole discretion, and you agree to not hold us liable for any adverse consequences that result from our decision.

11.14 **Restrictions on the Fund –** Neither you nor any beneficiary may sell, transfer, or pledge any interest in your HSA in any manner whatsoever, except as provided by law or this agreement.

The assets in your HSA will not be responsible for the debts, contracts, or torts of any person entitled to distributions under this agreement.

11.15 **What Law Applies –** This agreement is subject to all applicable federal and state laws and regulations. If it is necessary to apply any state law to interpret and administer this agreement, the law of our domicile will govern.

If any part of this agreement is held to be illegal or invalid, the remaining parts will not be affected. Neither your nor our failure to enforce at any time or for any period of time any of the provisions of this agreement will be construed as a waiver of such provisions or your right or our right thereafter to enforce each and every such provision.

GENERAL INSTRUCTIONS

Section references are to the Internal Revenue Code.

WHAT'S NEW

Additional Tax Increased – For tax years beginning after December 31, 2010, the additional tax on distributions not used for qualified medical expenses increases from 10 percent to 20 percent.

PURPOSE OF FORM

Form 5305-B is a model trust account agreement that has been approved by the IRS. An HSA is established after the form is fully executed by both the account owner and the trustee. The form can be completed at any time during the tax year. This account must be created in the United States for the exclusive benefit of the account owner.

Do not file Form 5305-B with the IRS. Instead, keep it with your records.

For more information on HSAs, see Notice 2004-2, 2004-2 I.R.B. 269, Notice 2004-50, 2004-33 I.R.B. 196, Pub. 969, *Health Savings Accounts and Other Tax-Favored Health Plans,* and other IRS published guidance.

DEFINITIONS

Identifying Number – The account owner's Social Security number will serve as the identification number of this HSA. For married persons, each spouse who is eligible to open an HSA and wants to contribute to an HSA must establish his or her own account. An employer identification number (EIN) is required for an HSA for which a return is filed to report unrelated business taxable income. An EIN is also required for a common fund created for HSAs.

High Deductible Health Plan (HDHP) – For calendar year 2011, an HDHP for self-only coverage has a minimum annual deductible of $1,200 and an annual out-of-pocket maximum (deductibles, co-payments, and other amounts, but not premiums) of $5,950. In 2012, the $1,200 minimum annual deductible remains the same and the annual out-of-pocket maximum increases to $6,050. For calendar year 2011, an HDHP for family coverage has a minimum annual deductible of $2,400 and an annual out-of-pocket maximum of $11,900. In 2012, the $2,400 minimum annual deductible remains the same and the annual out-of-pocket maximum increases to $12,100. These limits are subject to cost-of-living adjustments after 2012.

Self-Only Coverage and Family Coverage Under an HDHP – Family coverage means coverage that is not self-only coverage.

Qualified Medical Expenses – Qualified medical expenses are amounts paid for medical care as defined in section 213(d) for the account owner, his or her spouse, or dependents (as defined in section 152) but only to the extent that such amounts are not compensated for by insurance or otherwise. With certain exceptions, health insurance premiums are not qualified medical expenses.

Trustee – A trustee of an HSA must be a bank, an insurance company, a person previously approved by the IRS to be a trustee of an individual retirement account (IRA) or Archer MSA, or any other person approved by the IRS.

SPECIFIC INSTRUCTIONS

Article XI – Article XI and any that follow it may incorporate additional provisions that are agreed to by the account owner and trustee. The additional provisions may include, for example, definitions, restrictions on rollover contributions from HSAs or Archer MSAs (requiring a rollover not later than 60 days after receipt of a distribution and limited to one rollover during a one-year period), investment powers, voting rights, exculpatory provisions, amendment and termination, removal of trustee, trustee's fees, state law requirements, treatment of excess contributions, distribution procedures (including frequency or minimum dollar amount), use of debit, credit, or stored-value cards, return of mistaken distributions, and descriptions of prohibited transactions. Attach additional pages if necessary.

DISCLOSURE STATEMENT

REQUIREMENTS OF AN HSA

A. **Cash Contributions –** Your contribution must be in cash, unless it is a rollover contribution.

B. **Maximum Contribution –** The total amount that may be contributed to your HSA for any taxable year is the sum of the limits determined separately for each month. The determination for each month is based on whether, as of the first day of such month, you are eligible to contribute and whether you have self-only or family coverage under a high deductible health plan (HDHP). If you have self-only coverage, the maximum monthly contribution is 1/12 of $3,100 (for 2012). If you have family coverage, the maximum monthly contribution is 1/12 of $6,250 (for 2012). These 2012 limits are subject to cost-of-living increases. In addition, if you have attained age 55 before the close of the taxable year, the annual contribution limit is increased by an additional amount not to exceed $1,000 each year. The annual limit is decreased by aggregate contributions made to an Archer MSA and by any qualified HSA funding distributions from an IRA deposited into the HSA.

   If you become HSA-eligible after the beginning of the year, you may make a full year's contribution up to the statutory contribution limit as long as you maintain eligibility during the testing period. The testing period begins the last month of the initial eligibility year and ends at the end of the 12-month period following that month. If you do not remain eligible during the testing period, you must include in your gross income the contributions made for the months that you were not otherwise eligible and pay a 10 percent penalty tax on the amount.

C. **Contribution Eligibility –** You are an eligible individual for any month if you (1) are covered under an HDHP on the first day of such month; (2) are not also covered by any other health plan that is not an HDHP and that provides coverage for any benefit covered under the HDHP (with limited exceptions); (3) are not enrolled in Medicare; and (4) are not eligible to be claimed as a dependent on another person's tax return.

   In general, an HDHP is a health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses. Specifically, an HDHP has an annual deductible of at least $1,200 (for 2012) for self-only coverage and at least $2,400 (for 2012) for family coverage. In addition, the sum of the annual out-of-pocket expenses required to be paid (deductibles, copayments, and amounts other than premiums) cannot exceed $6,050 (for 2012) for self-only coverage and $12,100 (for 2012) for family coverage. All of these dollar amounts may be adjusted annually for cost-of-living increases.

D. **Nonforfeitability –** Your interest in your HSA is nonforfeitable.

E. **Eligible Trustees –** The trustee of your HSA must be a bank, savings and loan association, credit union, or a person or entity approved by the Secretary of the Treasury.

F. **Commingling Assets –** The assets of your HSA cannot be commingled with other property except in a common trust fund or common investment fund.

G. **Life Insurance –** No portion of your HSA may be invested in life insurance contracts.

INCOME TAX CONSEQUENCES OF ESTABLISHING AN HSA

A. **HSA Deductibility –** If you are eligible to contribute to your HSA for any month during the taxable year, amounts contributed to your HSA are deductible in determining adjusted gross income up to the maximum contribution limits discussed above. The deduction is allowed regardless of whether you itemize deductions. Employer contributions to your HSA are excludable from your gross income and you cannot deduct such amounts on your tax return as HSA contributions.

B. **Contribution Deadline –** The deadline for making an HSA contribution is your tax return due date (not including extensions). You may designate a contribution as a contribution for the preceding taxable year in a manner acceptable to us. For example, if you are a calendar-year taxpayer and you make your HSA contribution on or before your tax filing deadline, your contribution is considered to have been made for the previous tax year if you designate it as such.

C. **Excess Contributions –** An excess contribution is any amount that is contributed to your HSA that exceeds the amount that you are eligible to contribute. If the excess is not corrected timely, an additional penalty tax of six percent will be imposed upon the excess amount. The procedure for correcting an excess is determined by the timeliness of the correction as identified below.

   1. **Removal Before Your Tax Filing Deadline.** An excess contribution may be corrected by withdrawing the excess amount, along with the earnings attributable to the excess, before your tax filing deadline, including extensions, for the year for which the excess contribution was made. An excess withdrawn under this method is not taxable to you, but you must include the earnings attributable to the excess in your taxable income in the year in which the contribution was made. The six percent excess contribution penalty tax will be avoided.

2. **Removal After Your Tax Filing Deadline.** If you are correcting an excess contribution after your tax filing deadline, including extensions, remove only the amount of the excess contribution. The six percent excess contribution penalty tax will be imposed on the excess contribution for each year it remains in the HSA.

3. **Carry Forward to a Subsequent Year.** If you do not withdraw the excess contribution, you may carry forward the contribution for a subsequent tax year. To do so, you under-contribute for that tax year and carry the excess contribution amount forward to that year on your tax return. The six percent excess contribution penalty tax will be imposed on the excess amount for each year that it remains as an excess contribution at the end of the year.

You must file IRS Form 5329 along with your income tax return to report and remit any additional penalty taxes to the IRS.

D. **Tax-Deferred Earnings –** The investment earnings of your HSA are not subject to federal income tax until distributions are made (or, in certain instances, when distributions are deemed to be made).

E. **Taxation of Distributions –** Distributions taken from your HSA to pay for qualified medical expenses or to reimburse you for qualified medical expenses that you already paid are excluded from your gross income. Qualified medical expenses are amounts you pay for medical care (as defined in Internal Revenue Code Section (IRC Sec.) 213(d)) for yourself, your spouse, and your dependents (as defined in IRC Sec. 152), but only to the extent that such amounts are incurred after the HSA was established and are not covered by insurance or otherwise. For a general description of qualified medical expenses, refer to IRS Publication 502, *Medical and Dental Expenses,* available at www.irs.gov. Distributions made for purposes other than qualified medical expenses are included in your gross income and are subject to an additional 20 percent penalty tax. This additional 20 percent penalty tax will apply unless a distribution is made on account of (1) attainment of age 65, (2) death, or (3) disability.

Withdrawals from your HSA are not subject to federal income tax withholding.

F. **Rollovers –** Your HSA may be rolled over to another HSA of yours or may receive rollover contributions, provided that all of the applicable rollover rules are followed. Rollover is a term used to describe a tax-free movement of cash or other property between any of your HSAs. The general rollover rules are summarized below. These transactions are often complex. If you have any questions regarding a rollover, please see a competent tax advisor.

1. **HSA or Archer MSA to HSA Rollovers.** Assets distributed from your HSA may be rolled over to an HSA of yours if the requirements of IRC Sec. 223(f)(5) are met. A proper HSA to HSA rollover is completed if all or part of the distribution is rolled over not later than 60 days after the distribution is received. You may make only one rollover contribution to an HSA during a 12-month period.

   Assets distributed from your Archer MSA also may be rolled over to your HSA. A proper Archer MSA to HSA rollover is completed if all or part of the distribution is rolled over not later than 60 days after the distribution is received.

2. **Written Election.** At the time you make a rollover to an HSA, you must designate in writing to the trustee your election to treat that contribution as a rollover. Once made, the rollover election is irrevocable.

G. **Qualified HSA Funding Distributions –** If you are eligible to contribute to an HSA, you may be eligible to take a one-time, tax-free HSA funding distribution from your IRA and directly deposit it to your HSA. The amount of the qualified HSA funding distribution may not exceed the maximum HSA contribution limit in effect for the type of HDHP coverage (i.e., self-only or family coverage) that you have at the time of the deposit, and counts toward your HSA contribution limit for that year. If you do not remain HSA-eligible (for reasons other than death or disability) for 12 months following the transaction, the amount of the transaction is subject to taxation and a 10 percent penalty tax. For further detailed information, see IRS Publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans.*

H. **Beneficiary Issues –** If you die and your beneficiary is your spouse, your HSA (or the relevant portion thereof) will become your spouse's HSA as of the date of your death.

   If your beneficiary is not your spouse, the HSA (or the relevant portion thereof) will cease to be an HSA as of the date of your death.

   If the beneficiary is your estate, the fair market value of the account as of your date of death is taxable on your final tax return. For other beneficiaries, the fair market value of the account is taxable to that beneficiary in the tax year that includes the date of death.

LIMITATIONS AND RESTRICTIONS

A. **Deduction of Rollovers and Transfers –** A deduction is not allowed for rollover or transfer contributions.

B. **Prohibited Transactions –** If you or your beneficiary engage in a prohibited transaction with your HSA, as described in IRC Sec. 4975, your HSA will lose its tax-exempt status and you must include the value of your account in your gross income for that taxable year. Overdrawing your HSA is considered a prohibited transaction.

C. **Pledging –** If you pledge any portion of your HSA as collateral for a loan, the amount so pledged will be treated as a distribution and will be included in your gross income for that year.

OTHER

A. **IRS Plan Approval –** The agreement used to establish this HSA has been approved by the IRS. The IRS approval is a determination only as to form. It is not an endorsement of the plan in operation or of the investments offered.

B. **Important Information About Procedures for Opening a New Account –** To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial organizations to obtain, verify, and record information that identifies each person who opens an account. Therefore, when you open an HSA, you are required to provide your name, residential address, date of birth, and identification number. We may require other information that will allow us to identify you.

Managepoint

SALARY REDIRECTION AGREEMENT & CAFETERIA ENROLLMENT FORM
Plan Year 2021

A

Employer:	**Client #**	**EE #:**
Social Security Number:	Birthdate:	Gender: M F
NAME (Last):	(First):	(Middle Initial):
ADDRESS:	CITY/STATE:	ZIP:
Daytime Phone #:	Email Address:	

On separate benefit forms, I have enrolled for certain benefit coverage(s) and understand that an amount equal to the total amount of premium and/or contribution for coverage(s) (including Medical and Dependent Care Reimbursement plans) elected less any Non-elective Contributions allocable thereto will be withheld from my salary, continuing for each pay period until this agreement is amended or terminated. In the event of a third party carrier (insurance company), the premium increase or decrease can be deducted pre-tax. However, if this change is brought on by my employer, the increase must be deducted after-tax. I understand that my actual take-home pay may be higher or lower depending on the coverage I select. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes, therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Cafeteria Plan as elected in the pre-tax column. Any previous election and Salary Redirection Agreement under the Cafeteria Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of premium /contribution amount hereunder shall evidence acceptance of the Agreement.

B

Please check appropriate column for Pre-Tax/Post-Tax		
Circle One: WEEKLY BIWEEKLY SEMI-MONTHLY MONTHLY	**PRE-TAX**	**POST-TAX**
Group Medical Coverage		
Group Dental Coverage		
Group Vision Care		
Group Life Insurance		
Health FSA/Health Savings (HSA)		Not Applicable
Dependent Care FSA		Not Applicable
AFLAC Cancer Insurance		
ALLSTATE Group Hospital Plan		
ALLSTATE Group Critical Illness Plan		
ALLSTATE Group Accident Plan		
ALLSTATE Short-term Disability	Not Applicable	
MET LIFE Long-term Disability	Not Applicable	
Term/Whole/Universal Life	Not Applicable	
Pre Paid Legal Service Legal Plan	Not Applicable	
Other (please specify)	Not Applicable	
Other (please specify):		
Other (please specify):		
Other (please specify):		

C

WAIVER OF PRE-TAX PREMIUMS and/or REIMBURSEMENT UNDER THE CAFETERIA PLAN:
If a change of status occurs, I may have the right to sign on the plan(s) at that time.

(Only if Waiving Pre-Tax)
EMPLOYEE SIGNATURE:_____ **DATE:**_____

D

I want to enroll using PRE-TAX PREMIUMS and/or the REIMBURSEMENT ACCOUNTS under the Cafeteria Plan: The IRS regulation states four conditions. 1.) Any expenses for reimbursement must be within the plan year 2.) Any expenses you incur for reimbursement must not be covered by any other source such as insurance or HSA's. 3.) You must provide proper documentation in order to receive payment. 4.) You cannot change or revoke your elections during the plan year unless there is a specific change in status. Please see the Summary Plan Description.

EMPLOYEE SIGNATURE:_____ DATE:_____

IRS Guidelines/Section 125

Please note: Your group medical, dental, vision, life and many supplemental premiums are also under Section 125 and deducted on a pre-tax basis. This allows most people a 25 – 35% saving on these premiums through taxes not paid on these deductions. For most people, this option makes sense. However, if you are a person who is trying to build up their Social Security account for retirement, you may want to utilize the option of having these deductions taken from your check post-tax. The enrollment form has a check box for this option. For most of us, the opportunity to save on our federal, state, county, social security and medicare taxes is far more favorable. Your tax professional or the Social Security Administration can help you decide if you need to use the post tax option. Restrictions on the Section 125 also require that any deductions taken pre-tax may only be changed during the year with a qualifying life event or during open enrollment.

Managepoint **REQUEST FOR ADDITIONAL ENROLLMENT INFORMATION**

Name:_____ Company:_____

Work Phone:_____ Home Phone:_____

Personal Email:_____ Work Email:_____

As there are too many applications, forms and rates to include in this packet for the many additional products we offer, please check off the products of interest to you and return with your other documents. You may also fax them to 317-543-2020 or email benefits@managepoint.biz. A Managepoint representative will contact you shortly to provide the necessary information and enrollment options for these products. Please note: marking this form or the Salary Redirection Agreement does not enroll you in any product. Also, not all products are available in all states/job classes.

These products are available through payroll deduction

☐ Term, Whole or Universal Life Insurance

☐ Met Life Group Long Term Disability

☐ Veterinary Pet Health Insurance

☐ Life Lock Identity Theft Protection

☐ Legal Shield Legal Plan & Identity Theft

☐ Short Term and Senior Health Products

☐ Guarantee Issue AFLAC Short Term Disability

☐ Guarantee Issue Group Allstate Accident

☐ Guarantee Issue Group Allstate Hospital Indemnity

☐ Guarantee Issue Group Allstate Critical Illness

☐ Guarantee Issue Cincinnati Life Term and Whole

☐ Guarantee Issue Individual Dental or Vision

☐ AFLAC Cancer Plans

Products & services available through direct bill or bank draft

☐ Individual Dental and Vision options

☐ Medicare Supplement Coverage - *for those age 65 or older and/or*

☐ Auto, Truck, Motorcycle, RV, ATV or Watercraft coverage

☐ Home, Condo, Renters, Business or Personal Umbrella coverage

☐ General Business Liability and Property including Bonds, Workers Comp, Commercial Auto, E & O, D & O, etc.

FAX this form to 317-543-2020 or 800-337-1807

Group Accident Indemnity by Allstate Benefits

Guarantee Issue.
Provides generous cash benefits to the insured to assist with out of pocket expenses that come as the result of an Accident. These include, but are not limited to, deductibles, co-pays, co-insurance, lost time at work and more. Program includes up to $300k in Accidental Death benefits and office visits of any type at $75, 2 per person, 4 family max. This combined with pre-tax makes for a nearly cost free plan for some folks **Premiums range from $5.70/wk single to $14.65/wk family.**

Group Hospital Plan by Allstate Benefits

Guarantee Issue.
There are 3 different options available to fit your needs. The 1st is designed to supplement major medical coverage and help with out of pocket expenses from any type of hospitalization. The other two add to this coverage and provide more protection from sickness and accident events as well as planned and unplanned surgeries. Benefits are paid regardless of other coverage and increase 5% each year for the 1st 5 years. Program includes an annual $50 wellness benefit per person as well as an RX benefit in the Medium and High plans. Rates based on age and plan selected.

Short Term Disability by Aflac

Guarantee Issue available.

- Maximum $5000/mo or 60% of monthly income replacement, whichever is less. $400/mo minimum benefit, regardless of income
- Varied benefit periods of 3, 6, 12 or 24 months
- Varied waiting periods of 7, 14, 30, 90 or 180 days

Available through age 64, guaranteed renewable to age 70, post-tax payroll deduction only. Rates based on job class, age & income

Group Long Term Disability by Met-Life

Not available to all job classes, contact us for eligibility

- 60% of compensation up to $6000 per month with a $100 per month minimum benefit
- 180 benefit waiting period, age banded rates, but not locked in
- Benefit period to SS Retirement Age, own occupation 2 years

Available through age 64, guaranteed renewable to age 70, post-tax payroll deduction only. Rates based on job class, age & income

Individual Dental and/or Vison Protection

We have several carriers who to allow additional dental and /or vison protection to either supplement current group coverage or set up a stand alone plan. We have indemnity type plans to standard plans with limit ranges from $750 to $2000 annual benefit. *Eligible for coverage through age 70. Rates based on benefit levels chosen*

Life Lock Benefit Solutions

Protect your identity and insure you have adequate resources to restore your credit in the event of an identity theft. Basic Program includes Credit Alerts, lost Wallet protection, Address change verification, black market website surveillance, reduced pre-approved credit card offers, $1 million total service guarantee. Ultimate programs adds alias name and address monitoring, court scanning, files sharing network searches, unauthorized payday loan notifications, sex offender registry reports, bank application/ takeover alerts, annual online credit reports and scores, as well as monthly credit score tracking! *Rates start at $1.96 individual for Basic, to $12.01 Family for Ultimate protection per week.*

Group Critical Illness Plan by Allstate Benefits

Guarantee Issue.
Inexpensive and affordable program to add protection for life's most expensive events. 2 options will pay either $10k or $20,000 lump sum benefit in the event of a heart attack, stroke, major organ transplant, internal cancer, or kidney failure. $2,500 or $5k benefits for coronary by-pass or cancer in situ. Wellness benefit or either $50 or $75 per person per year. This combined with pre-tax makes for a nearly cost free plan for some folks Age banded rates start as low as $1.70.wk for a single 18-35, non-tobacco.

Term, Whole & Universal Life No Med Exam

Guarantee Issue.
Coverage from Cincinnati Life is guaranteed issue for the EE through $100k. Similar coverage is available for spouse and dependents. Programs include Term, Return of Premium, Whole and Universal Life. Coverage is available from $10k to $500k. Term policy has options for 10, 20 & 30 years Waiver of Premium and Accelerated Benefits included Policies lock in at age written and portable. Higher underwritten benefits available from other carriers

Cancer Plans by Aflac

Benefits include Initial Treatment Benefit, Chemotherapy/Radiation, Experimental treatments, Immunotherapy, Anti-Nausea, Stem Cell & Bone Marrow Transplants, Blood & Plasma, Surgical/Anesthesia, Skin Cancer, Hospital Confinement, Outpatient Surgery, Extended Care, Home Health Care, Hospice, Nursing Services, Prosthetics, Reconstructive Surgery, Ambulance, and Continuation of Coverage Annual Cancer Screenings and Initial Diagnosis Benefits.
Available through age 70 and eligible for pre-tax deduction

Identity Theft & Legal Plans by Legal Shield

Identity Theft:Plan

- An up-to-date credit report through Experian at no added cost.
- A personal credit score by an independent scoring svc & analysis.
- Continuous credit monitoring
- Identity Restoration—trained expert will take the steps to help restore your name and credit for you.

Legal Plan

- Unlimited telephone consultations, personal letters written on your behalf, and a **Will and Testament** updated annually
- Motor Vehicle Violation representation
- Trial Defense hours—grow annually first 5 years in the plan
- IRS Audit representation every year after you join the plan
- Discount with reputable law firm for other legal concerns

Individual Short Term & Senior Health Plans

- Assistance in determining plan eligibility
- Professional consultation for short term and senior plans
- A large selection of Traditional Medicare, RX Part D, plans, Medigap options as well as Medicare Advantage plans

Veterinary Pet Health Insurance Plans

Major Plan: Benefits for some hereditary items after 1 yr of coverage. Chronic conditions included, Flexible deductibles, Benefits to $14k/yr
Rates average $11 - $16 per week, wellness optional
Economy Plan:Same as major, but limited to $7k/ yr in benefits
Rates average $9 - 12 per week, wellness optionsl
Feline Select: Just for cats. Covers 15 most common conditions. No deductible. Maximum benefit of $9k per year.
Rate is $5/wk, wellness optional
Avian & Exotic Plans: Benefits and rates depends on the animal to be covered.

RMIA **RiskManagers** Insurance Agency

www.rmiainc.com
rmia@managepoint.biz
Office: 317-549-8862
FAX: 317-549-9119