2022-2023
EMPLOYEE BENEFITS GUIDE
Williamson County Special Education District

Table of Contents

Table of Contents 1
Enrollment & Eligibility 2
Medical Insurance 3
Health Reimbursement Arrangement (HRA) 5
Dental Insurance 9
Vision Insurance 10
Life and AD&D Insurance 11
Voluntary Life 11
Contacts 14
Enrollment Forms 16
Required Notices 26

This brochure summarizes the benefit plans that are available to Southern Illinois Health and Wellness Insurance Trust eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

Enrollment & Eligibility

Benefits Open Enrollment is Here!

Welcome to your 2022-2023 employee benefits guide. In these pages, you'll learn about the Southern Illinois Health and Wellness Insurance Trust benefits program, which is designed to help you stay healthy, secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace. Please read the information in this guide carefully, and for full details about our plans, refer to each plan's summary plan description

Who is Eligible?

Employees and eligible dependents may participate in the benefit program.

- Certified / Administrators / Classified /Non-Certified – full-time employees who regularly scheduled to work at least 27.5 hours of service per week.

Generally, for the Southern Illinois Health and Wellness Insurance Trust benefits program, dependents are defined as:

- Your legal spouse
- Dependent child(ren) up to age 26

When and How Can I Enroll?

Open enrollment is in August of each year.

All eligible employees are required to complete the enrollment process, even if you do not want to make changes to your benefits.

When is Coverage Effective?

You are eligible for coverage on the first of the month following or coincident with 30 days of continuous full-time employment.

Changing Coverage During the Year

You can change coverage during the year only when you experience a qualifying life event, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage. The change must be reported to the Human Resources Department within 30 days of the event. The change must be consistent with the event.

For questions about your benefits, contact Ciara Zambito at USI Insurance Services or visit www.sihwit.com.

ciara.zambito@usi.com

314-342-7128

Medical Insurance

Southern Illinois Health and Wellness Insurance Trust offers medical coverage through Meritain Health utilizing the Aetna network. The below chart is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

	Plan A Wellness Compliant Plan		Plan A Wellness Non-Compliant Plan		Plan B	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Annual Deductible						
Individual	$750	$3,000	$975	$3,000	$5,000	$10,000
Family	$2,250	$9,000	$2,925	$9,000	$10,000	$20,000
Coinsurance	90%	70%	90%	70%	80%	60%
Maximum Out-of-Pocket						
Individual	$1,500	$6,000	$1,725	$6,000	$6,350	$12,800
Family	$4,500	$18,000	$5,175	$18,000	$12,700	$25,600
Physician Office Visit						
Primary Care	$30 copay	70% after deductible	$39 copay	70% after deductible	80% after deductible	60% after deductible
Specialty Care	$30 copay	70% after deductible	$39 copay	70% after deductible	80% after deductible	60% after deductible
Preventive Care						
Adult Periodic Exams	$30 copay	70% after deductible	$39 copay	70% after deductible	100%	60% after deductible
Well-Child Care	$30 copay	70% after deductible	$39 copay	70% after deductible	100%	60% after deductible
Colonoscopy	100%, deductible waived	70% after deductible	100%, deductible waived	70% after deductible	100%	60% after deductible
Mammograms	100%, deductible waived	70% after deductible	100%, deductible waived	70% after deductible	100%	60% after deductible
Diagnostic Services						
X-ray and Lab Tests	90% after deductible	70% after deductible	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Complex Radiology	90% after deductible	70% after deductible	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Urgent Care Facility	$30 copay	70% after deductible	$39 copay	70% after deductible	80% after deductible	60% after deductible
Emergency Room Facility Charges	$150 copay	$150 copay	$150 copay	$150 copay	80% after deductible	60% after deductible
Inpatient Facility Charges	90% after deductible	70% after deductible plus $300 copay	90% after deductible	70% after deductible plus $300 copay	80% after deductible	60% after deductible
Outpatient Facility and Surgical Charges	90% after deductible	70% after deductible	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Mental Health						
Inpatient	90% after deductible	70% after deductible plus $300 copay	90% after deductible	70% after deductible plus $300 copay	80% after deductible	60% after deductible

	Plan A Wellness Compliant Plan		Plan A Wellness Non-Compliant Plan		Plan B	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Outpatient	$30 copay	70% after deductible	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Substance Abuse						
Inpatient	90% after deductible	70% after deductible plus $300 copay	90% after deductible	70% after deductible plus $300 copay	80% after deductible	60% after deductible
Outpatient	$30 copay	70% after deductible	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Other Services						
Chiropractic	90% after deductible	70% after deductible	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Retail Pharmacy (30 Day Supply)						
Tier 1	$10 copay	Not covered	$10 copay	Not covered	$10 copay	Not covered
Tier 2	$30 copay	Not covered	$30 copay	Not covered	$20 copay	Not covered
Tier 3	$50 copay	Not covered	$50 copay	Not covered	$50 copay	Not covered
Tier 4	$100 copay	Not covered	$100 copay	Not covered	$100 copay	Not covered
Mail Order Pharmacy (90 Day Supply)						
Tier 1	$20 copay	Not covered	$20 copay	Not covered	$20 copay	Not covered
Tier 2	$60 copay	Not covered	$60 copay	Not covered	$60 copay	Not covered
Tier 3	$100 copay	Not covered	$100 copay	Not covered	$100 copay	Not covered
Tier 4	$200 copay	Not covered	$200 copay	Not covered	$200 copay	Not covered

*Visit limits may apply to certain benefits. Please refer to the Summary Plan Description for additional details.

Health Reimbursement Arrangements

A high-deductible health plan may offer you the greatest premium savings. But the very reason it's so cost-effective is that you, as the consumer, pay more health care costs in the form of a high deductible—the amount you pay out of your own funds before the plan begins to pay.

Your employer does not expect you to meet your annual deductible completely out of your own pocket. An HRA is funded for you by your employer. And you can use your HRA dollars to help meet your deductible.

Here's how an HRA works:

Your employer creates an HRA for you, providing a stated amount of money.

This money belongs to your employer until you use it to pay qualified expenses.

Only expenses incurred after the effective date of the HRA are eligible.

The HRA funds are never counted as income for you.

The HRA funds are not portable—that is, they don't go with you if you leave your job.

Your HRA provides financial balance and flexibility—in one neat package!

These materials were created to help you understand the benefits available to you. This is not a Summary Plan Description and is not intended to replace the benefit summary or schedule of benefits contained within the Plan. If any provision of these materials is inconsistent with the language of the Plan, the language of the Plan will govern. Meritain Health® is not an insurer or guarantor of benefits under the Plan.

Understanding Your HRA

Here's how an HRA works

A Health Reimbursement Arrangement (HRA) allows you to use tax-free dollars to pay for eligible health care expenses not reimbursed by a medical plan.

What does my employer's HRA cover?

Your HRA only covers expenses applied to your medical deductible. Covered benefits and services are variable and subject to change.

Frequently Asked Questions About HRAs

If I have a question about my HRA, who should I call?

You can contact your dedicated service team for help with questions, or for more information about your benefits. The phone number for Meritain Health Customer Service is **1.800.566.9305, option 5**.

What if I still have money in my HRA at year's end?

If there is a balance in your HRA at the end of the plan year, those funds are forfeited back to your employer.

How will I know what my HRA balance is?

You can access your account balance online at **www.meritain.com**.

HRA Reminders

Group number

18153

Plan year

1/1/2022–12/31/2022

HRA Reimbursement deposits

Deposited into your account bi-weekly

Out-of-pocket requirement

Your plan has a bridge/deductible requirement which is the amount of your deductible you must pay out-of-pocket before you are eligible to receive HRA reimbursements. You are already enrolled in the automatic reimbursement feature, meaning all of your eligible deductible expenses are being applied on your behalf. Once you meet the out-of-pocket requirement the HRA dollars will automatically start reimbursing to you! You can check your out-of-pocket balance at any time by visiting your HRA account online.

For online claim status inquiry, log on to www.meritain.com

Access to **www.meritain.com** is as easy as 1-2-3!

Step 1: Open your web browser and go to **www.meritain.com**.

Step 2: Register your account. Click *Create a new user account*.

You will need to fill in your:

- Member ID
- Date of birth
- First and last name
- Zip code
- Group number
- Email address
- Member type (subscriber or dependent)

Step 3: Set up your username and password.

Step 4: Click on the *Flex/CHDP Accounts* link and you will be connected to your HRA account.

Questions?

For additional plan information you can contact Meritain Health Customer Service at **1.800.566.9305, option 5**.

HRA Reimbursement Made Easy!

What is the auto-reimbursement feature?

Your employer has opted to have the HRA plan process your health care eligible expenses, applied to the deductible, on coverage through Meritain Health, automatically. If you are enrolled in the HRA, you are already participating in this feature, while an active employee of SIHWIT. Once you have met the required out-of-pocket amount, you will be reimbursed through your Meritain Health HRA plan up to the annual benefit amount provided.

Mandatory Direct Deposit for HRA Reimbursements

SIHWIT requires all employees who participate in the benefit plans receive their eligible reimbursements via direct deposit. The direct deposit account must be established in order to avoid delays in the disbursement of your benefit dollars. There are several valuable advantages to direct deposit reimbursement; it eliminates the handling of physical negotiable checks, it's secure, confidential, convenient and fast. Your reimbursement(s) will be deposited directly to the financial institution account of your choice. Don't delay, sign-up today! Please complete the direct deposit set-up form included in this kit.

How to sign up for direct deposit

As soon as possible, complete and return the setup form included in this mailing to:

Meritain Health
P.O. Box 30111
Lansing, MI 48909

Fax to: **1.888.837.3725**

Along with the setup form, you will need to provide a copy of a voided check listing your account and bank routing (transit) numbers. There is no set-up fee, and this is a one-time set-up process. You will only need to repeat this process in the event that your bank account information changes.

If you have any questions regarding direct deposit, please contact Meritain Health Customer Service at 1.800.566.9305, option 5.

Dental Insurance

Southern Illinois Health and Wellness Insurance Trust offers dental insurance through Delta Dental of Illinois. You will maximize your benefits by receiving care from a Delta Dental PPO or Delta Dental Premier network dentist. You may register on Delta Dental of Illinois' website, www.deltadentalil.com. Once registered, you can get real time benefit information, check claim status, sign up for electronic Explanation of Benefits and print a temporary ID card.

To find a Dentist, visit www.deltadentalil.com and click on "Provider Search"

	Delta Dental of Illinois		
	Delta Dental PPO	Delta Dental Premier	Non-Network
Annual Deductible			
Individual	$50	$50	$50
Family	$150	$150	$150
Waived for Preventive Care?	Yes	Yes	Yes
Annual Maximum			
Per Person / Family	$1,000	$1,000	$1,000
Preventive	100%	100%	100%
Basic	90%	80%	80%
Major	60%	50%	50%
ToGo Carryover Feature	Your plan allows you and your covered dependents to carry over qualified unused portions of your annual maximum from one year to the next		
Orthodontia			
Benefit Percentage	50%	50%	50%
Dependent Child(ren)	Up to age 19	Up to age 19	Up to age 19
Lifetime Maximum	$1,000	$1,000	$1,000

Employee Contributions (Monthly)	
Employee	$27.34
Employee & Spouse	$54.70
Employee & Child(ren)	$62.17
Family	$92.59

Vision Insurance

Southern Illinois Health and Wellness Insurance Trust provides vision insurance through EyeMed Vision Care. Create a member account at www.eyemed.com/member. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App.

	EyeMed Vision Care *Insight Network*
Copay	
Routine Exams (Annual)	$10 copay
Vision Materials	
Standard Plastic Lenses • Single • Bifocal • Trifocal • Lenticular	$25 copay
Progressive – Standard Lenses	$90 copay
Progressive – Premium Tier 1-3 Lenses	$110-$135 copay
Progressive – Premium Tier 4 Lenses	$90 copay; 20% off retail price less $120 allowance
Contacts (Covered in lieu of frames) • Conventional • Disposable • Medically Necessary	• $0 copay $130 allowance; 15% off balance over $130 allowance • $0 copay; 100% off balance over $130 allowance • $0 copay
Frames	$0 copay; 20% off balance over $130 allowance
Benefit Frequencies • Exam • Frames • Lenses • Contacts	Once every 12 months

Employee Contributions (Monthly)	
Employee	$5.21
Employee & Spouse	$9.91
Employee & Child(ren)	$10.43
Family	$15.34

Life and AD&D Insurance

Williamson County Special Education District provides basic Life and A&D benefits to eligible employees. Be sure to designate a beneficiary for the life insurance benefit. Your beneficiary form should be updated annually and kept on file with human resources.

Hartford Life and Accident Insurance Co.	
You	
Benefit Maximum	$20,000
Guaranteed Issue	$20,000

The above benefits begin to decrease at age 65.

Voluntary Life

In addition to the Basic Life and AD&D coverage, you have the option to purchase additional voluntary life insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. Your election, however, could be subject to medical questions and evidence of insurability.

Hartford Life and Accident Insurance Co.	
You	
Benefit	Increments of $10,000
Benefit Maximum	$100,000
Guarantee Issue - Initial Eligibility - Any other time	 $100,000 All amounts require Evidence of Insurability
Spouse	
Benefit	Increments of $5,000
Benefit Maximum	The lesser of 100% of your supplemental coverage or $50,000
Guarantee Issue - Initial Eligibility - Any other time	 $30,000 All amounts require Evidence of Insurability
Children	
Benefit	Increments of $5,000
Benefit Maximum	$10,000

Voluntary Life Insurance

You may purchase additional Life insurance with Hartford Life and Accident Insurance Co if you want more coverage. Your contributions will depend on your age and the amount of coverage you elect. You must enroll in coverage in order to purchase coverage for your spouse and/or child/ren.

Life and Disability insurance from The Hartford can help you protect the financial future of your loved ones. Your coverage includes valuable services that can help you and your family.

FUNERAL CONCIERGE SERVICES

Helps provide peace of mind when it's needed most.

The Hartford's Funeral Concierge offers a suite of online tools and live support to help guide you through key decisions. It allows for pre-planning, documentation of wishes, and even offers cost comparisons of funeral-related expenses. After a loss, this service includes family advocacy and professional negotiation of funeral prices with local providers – often resulting in significant savings.

For more information, call: **1-866-854-5429**
Visit: **www.everestfuneral.com/hartford**
Use code: **HFEVLC**

BENEFICIARY ASSIST® COUNSELING SERVICES

Getting through a loss is hard. Getting support shouldn't be.

The Hartford offers you Beneficiary Assist counseling that can help you or your beneficiaries (named in your policy) cope with emotional, financial and legal issues that arise after a loss. Includes unlimited phone contact with a counselor, attorney or financial planner and five face-to-face sessions for up to a year from the date a claim is filed.

For more information, call: **1-800-411-7239**

ESTATEGUIDANCE® WILL SERVICES

Create a simple will from the convenience of your home.

Whether your assets are few or many, it's important to have a will. Through The Hartford you have access to EstateGuidance®. It helps you protect your family's future by creating a will online – backed by online support from licensed attorneys.

Visit: **www.estateguidance.com**
Use code: **WILLHLF**

Travel Assistance

Call toll-free: **1-800-243-6108**
From other locations,
call collect: **202-828-5885**
Fax: **202-331-1528**

What to have ready:

- Your employer's name
- Your phone number
- Nature of the problem
- Your policy number
- Your Travel Assist ID number: **GLD-09012**

Ability Assist® & HealthChampion℠

Call toll-free:
1-800-96-HELPS
(1-800-964-3577)

(Snap a photo with a mobile device to capture information above.)

TRAVEL ASSISTANCE WITH ID THEFT PROTECTION

Even the best planned trips can be full of surprises.

Travel Assistance with ID Theft Protection includes pre-trip information to help you feel more secure while traveling. It can also help you access professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less. ID Theft services are available to you and your family at home or when traveling.

In case of a serious medical emergency while traveling, please obtain emergency medical services first (contact the local "911"), and then contact Travel Assistance to alert them.

ABILITY ASSIST® COUNSELING SERVICES WITH HEALTHCHAMPION℠ HEALTH CARE SUPPORT

Disability can be a challenge. Getting support doesn't have to be.

Ability Assist Counseling Services offers 24/7 access to master's- and Ph.D.- level clinicians. Includes three face-to-face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal and work-life concerns.

If your company provides disability coverage for less than 5,000 people, Ability Assist is available to you at any time if you're covered by Disability, Voluntary or Leave Management services with The Hartford. If your company provides disability coverage for more than 5,000 people, you'll have access to this service once you have an approved claim. See your benefits manager for details.

HealthChampion offers support if you've become disabled or are diagnosed with a critical illness. You'll receive guidance on care options, helpful resources and help with timely and fair resolution of issues.

Contacts

Additional information regarding benefit plans can be found on www.SIHWIT.com. Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

Carrier Customer Service

Benefits Plan	Carrier	Phone Number	Website
Medical PPO	Meritain Health (TPA)	800-925-2272	www.meritain.com
Dental Triple Option	Delta Dental of Illinois	1-800-323-1743	www.deltadentalil.com
Vision	EyeMed Vision Care	866-723-0513	www.eyemed.com
Life and AD&D	Hartford Life and Accident Insurance Co	1-800-523-2233	www.thehartford.com

Your Guide to Enrollment

Completing your enrollment

Complete, sign and return your enrollment form to your employer within 30 days of your eligibility date whether you're enrolling or declining benefits.

- **Write clearly.** If your form is unreadable, your enrollment may be delayed, or incorrect.
- **Don't forget the back side.** Missing or incomplete information will delay your enrollment.
- **Sign and date your enrollment form.** Remember to sign and date the form, even if you're declining benefits.

Helpful tips

- Your health care plan includes a network of providers you can visit for health care services. When you visit providers in this network, you will receive the best service rate. Call the provider information number for participating providers.
- Your name, identification number, medical group number and your group name, are used to identify you and your covered dependents' benefits.
- Your medical copays are listed for you and your providers.
- Your pharmacy coverage information is listed on the front of your card, and includes the Meritain Health Pharmacy Solutions customer service number and prescription copays..
- Please ensure that you precertify with medical management, if required.
- All claims should be submitted to Meritain Health at the address listed on the back of your card.
- You or your provider can call Meritain Health to verify eligibility of benefits or check on your claims status.
- You can call for information on a doctor or specialist who is close to you and serves your specific needs.

All eligible employees must complete the enrollment form, whether you're choosing this plan or declining benefits. Your enrollment form is included in the back of this packet.

COMPANY NAME: Southern Illinois Health & Wellness Insurance Trust **GROUP #:** Williamson Special Education #E8153

BENEFIT ENROLLMENT FORM

MERITAIN® HEALTH
An Aetna Company

THIS FORM IS TO BE COMPLETED FOR NEW ENROLLMENTS AND COVERAGE CHANGES

PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM
(ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

EMPLOYEE INFORMATION – ALL INFORMATION IS REQUIRED

LAST NAME	FIRST NAME	MI

SOCIAL SECURITY NO.	DATE OF BIRTH (MM/DD/YY)	GENDER	MARITAL STATUS
		☐ M ☐ F	☐ Single ☐ Married ☐ Divorced ☐ Widowed

MAILING ADDRESS	CITY	STATE	ZIP

EMAIL ADDRESS

PRIMARY PHONE NUMBER	PHONE TYPE
	☐ HOME ☐ CELL ☐ WORK

ARE YOU THE **EMPLOYEE** COVERED UNDER **ANY** OTHER INSURANCE? ☐YES ☐NO (i.e. Medicare, Tricare, spouse's plan)

IF YES, NAME OF INSURANCE: _____ EFFECTIVE DATE: _____

TYPE OF POLICY (Retiree, COBRA, Spouse): _____ POLICY HOLDER (Self, Spouse): _____

IF ENROLLED IN MEDICARE: EFFECTIVE DATE: PART A _____ PART B _____ MEDICARE ID _____

ENTITLEMENT TO MEDICARE DUE TO: ☐ AGE ☐ DISABILITY ☐ END STAGE RENAL DISEASE (ESRD)

EMPLOYER USE ONLY

DATE OF HIRE	EFFECTIVE DATE

DIVISION #	DEPT. # / CLOCK #

ANNUAL SALARY: $

☐ HOURLY ☐ SALARY

☐ NEW ENROLLMENT
- ☐ Active ☐ Retiree
- ☐ Full Time ☐ Part Time
- ☐ COBRA

☐ ENROLLMENT CHANGE
- ☐ Marriage ☐ Birth ☐ Adoption
- ☐ Reinstatement ☐ Loss of Coverage
- ☐ Other: _____

Employer Representative Signature: _____

Date: _____

BENEFIT SELECTION

COVERAGE TYPE	PLAN ELECTED (IF APPLICABLE)	COVERAGE LEVEL
☐ MEDICAL/RX		☐ SINGLE ☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + CHILD ☐ FAMILY ☐ DECLINE

DEPENDENT INFORMATION

(ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED. PROVIDE THE CONTACT INFORMATION FOR ALL ADULT DEPENDENTS AGE 18 AND OVER.)

Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP). If an employee or eligible dependent did not enroll in the plan when initially eligible, he or she will be permitted to later enroll in the plan under one of the following circumstances:

a. The employee or eligible dependent loses their eligibility status to participate in Medicaid or CHIP; or

b. The employee or eligible dependent qualifies for premium assistance under Medicaid or CHIP at the state level in which the individual resides.

The employee or eligible dependent must request enrollment in the plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days of being notified of eligibility for premium assistance from the state in which the individual resides.

DEPENDENT 1 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE			SOCIAL SECURITY NO (REQUIRED)	RELATIONSHIP (REQUIRED)	CHECK COVERAGE
DATE OF BIRTH (MM/DD/YY)	GENDER ☐ M ☐ F	PHONE NUMBER	☐ HOME ☐ CELL ☐ WORK	EMAIL ADDRESS	☐MEDICAL/RX
DEPENDENT 2 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE			SOCIAL SECURITY NO (REQUIRED)	RELATIONSHIP (REQUIRED)	CHECK COVERAGE
DATE OF BIRTH (MM/DD/YY)	GENDER ☐ M ☐ F	PHONE NUMBER	☐ HOME ☐ CELL ☐ WORK	EMAIL ADDRESS	☐MEDICAL/RX
DEPENDENT 3 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE			SOCIAL SECURITY NO (REQUIRED)	RELATIONSHIP (REQUIRED)	CHECK COVERAGE
DATE OF BIRTH (MM/DD/YY)	GENDER ☐ M ☐ F	PHONE NUMBER	☐ HOME ☐ CELL ☐ WORK	EMAIL ADDRESS	☐MEDICAL/RX
DEPENDENT 4 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE			SOCIAL SECURITY NO (REQUIRED)	RELATIONSHIP (REQUIRED)	CHECK COVERAGE
DATE OF BIRTH (MM/DD/YY)	GENDER ☐ M ☐ F	PHONE NUMBER	☐ HOME ☐ CELL ☐ WORK	EMAIL ADDRESS	☐MEDICAL/RX
DEPENDENT 5 FULL NAME (REQUIRED) LAST, FIRST, MIDDLE			SOCIAL SECURITY NO (REQUIRED)	RELATIONSHIP (REQUIRED)	CHECK COVERAGE
DATE OF BIRTH (MM/DD/YY)	GENDER ☐ M ☐ F	PHONE NUMBER	☐ HOME ☐ CELL ☐ WORK	EMAIL ADDRESS	☐MEDICAL/RX

*IF ANY OF THE DEPENDENTS LISTED ABOVE HAVE A MAILING ADDRESS THAT DIFFERS FROM THE EMPLOYEE, PLEASE COMPLETE THE INFORMATION BELOW:

DEPENDENT	MAILING ADDRESS	CITY	STATE	ZIP

*IF YOUR CHILD IS MENTALLY OR PHYSICALLY DISABLED, PLEASE PROVIDE APPROPRIATE DOCUMENTATION. LIST THE NAME(S) OF ANY DISABLED DEPENDENTS:

DEPENDENT	DEPENDENT	DEPENDENT

COMPANY NAME: **Southern Illinois Health & Wellness Insurance Trust**

COORDINATION OF BENEFITS – SPOUSE INFORMATION (IF APPLICABLE) COMPLETE **ALL** QUESTIONS

IS YOUR SPOUSE EMPLOYED? ☐YES ☐NO IF **YES**, ☐FULL TIME ☐PART TIME SPOUSE EMPLOYER NAME: SPOUSE DATE OF BIRTH:

INDICATE THE COVERAGE, CARRIER NAME AND EFFECTIVE DATE THAT YOUR SPOUSE IS **ENROLLED** IN WITH HIS/HER EMPLOYER

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
☐MEDICAL					
☐PRESCRIPTION					
☐DENTAL					
☐VISION					

COORDINATION OF BENEFITS – DEPENDENT CHILD(REN) INFORMATION (IF APPLICABLE) COMPLETE **ALL** QUESTIONS

ARE ANY OF YOUR DEPENDENT CHILD(REN) COVERED BY ANOTHER PARENT/GUARDIAN OR PLAN NOT LISTED ABOVE? ☐YES ☐NO
EMPLOYER PROVIDING COVERAGE:
IF **YES**, COMPLETE THE QUESTIONS BELOW

TYPE OF OTHER COVERAGE	CARRIER NAME	CARRIER ADDRESS	EFFECTIVE DATE (MM/DD/YY)	TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)	COURT ORDER REQUIRING COVERAGE (I.E. DIVORCE DECREE, QMCSO)*	LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN
☐MEDICAL						
☐PRESCRIPTION						
☐DENTAL						
☐VISION						

***COPY OF THE COURT ORDER MUST BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN CLAIMS BEING DENIED.**

COORDINATION OF BENEFITS – GOVERNMENTAL INSURANCE (I.E. MEDICARE, MEDICAID,TRICARE, ETC.)

IS YOUR SPOUSE AND/OR ARE ANY DEPENDENTS ENROLLED IN ANY GOVERNMENTAL INSURANCE? ☐YES ☐NO IF **YES**, PLEASE COMPLETE BELOW

LIST ALL FAMILY MEMBERS ENROLLED	TYPE OF COVERAGE	EFFECTIVE DATE OR IF MEDICARE COVERAGE, PART A EFFECTIVE DATE	PART B EFFECTIVE DATE (IF APPLICABLE)	MEDICARE ID NUMBER	IS MEDICARE COVERAGE DUE TO:
					☐AGE ☐DISABILITY ☐ESRD
					☐AGE ☐DISABILITY ☐ESRD

PLAN DECLARATION

I understand that the above elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless I make an election change permitted under the Plan. I understand that I may change my elections during the Plan Year only if (i) I experience a "status change", as defined under the Plan, and if my change in elections is consistent with that "status change", (ii) I exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Election Form during the appropriate annual election period to change or terminate that coverage. I also understand, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase the payroll deductions, if any, I am required to make per pay period to pay for that benefit option. I understand further that, except to the extent that I am permitted to make a change under the Plan, the payroll deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options I have elected above.

I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that the employer may modify my elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

NOTICE OF SPECIAL ENROLLMENT PERIODS

If you are declining enrollment in the Plan's health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan's health coverage features if you or your dependents lose eligibility for that coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Human Resources representative.

SIGNATURE AND AUTHORIZATION

EMPLOYEE SIGNATURE	PRINT EMPLOYEE NAME	DATE

Direct Deposit Authorization Form

MERITAIN® HEALTH
An Aetna Company

Send a completed form with voided check or deposit slip through one of the following options:

Fax: 1.716.541.6636

Add/update online: www.meritain.com
Select the *Flex/CDHP* link to access your account, then select the *Tools and Support* tab, under the *How do I?* section. Finally, select the *Change Payment Method* option and follow the instructions.

Questions: 1.800.566.9305, option 5.

To be reimbursed directly into your bank account,
Please complete this form and fax it to the number on the right.
To finalize set-up, additional validation will be required, please review condition 5 below.

Type of Request	☐ New	☐ Change	☐ Cancellation

Employee Information	Employer:	Meritain Health ID:
Name: (last, first, initial)		Home/Personal Phone:
Address:		Work Phone:
City:	State:	Zip Code:

Financial Information	Name(s) on the account:	
Bank or Financial Institution:		Routing/Transit Number:
Address:		Account Number:
City:	State: / Zip code:	☐ Checking Account ☐ Savings Account*

Voided check (for checking account) or deposit slip (for savings account*) - REQUIRED (***Please place directly below)***

Terms and Conditions

1. You must complete, sign, and date this authorization form to enroll in the direct deposit program. If you have a joint account, the form must be signed by both parties. Once your form is received by Meritain Health, there may be up to a 7- 10 business day time period before the direct deposit becomes effective. Any claims paid during this time will be mailed to you as a check.

2. In order to take advantage of the direct deposit program, your financial institution must be a member of an Automated Clearing House (ACH).

3. You will receive a direct deposit statement each time an electronic transfer is made to your account. The statement will indicate what claims are paid, as well as year-to-date information on your reimbursement account. It can take up to 72 hours for a payment to post into your account after Meritain Health transmits the funds**. Please verify that the deposit has been made into your account before attempting to withdraw funds**.

4. It is your responsibility to notify Meritain Health of any changes to your bank account, such as a closure, or a change in the account number. Complete this form with the new information, and check the change box. There may be up to a 7-10 business day processing period before the change becomes effective. During this time, you will receive checks for any reimbursement claims paid.

5. Due to required security measures set by the National Automated Clearing House Association (NACHA), you will be required to take additional actions after the initial entry of your bank account information.

Once your bank account information has been added, a micro deposit transaction will be processed. A micro deposit is a random credit and debit transaction, the amount ranges between $0.01 and $0.99, Meritain does not control the amount processed.

Once the micro deposit is confirmed you must validate the bank account via the member portal, the mobile app or by contacting our customer service team.

This is a time sensitive matter; you will have 30 calendar days to validate the amount from the time the transaction is initially processed.

If you do not validate within the 30 calendar days, the bank account on file will expire and will be updated to an inactive status.

Presence of bank account information does not guarantee a direct deposit disbursement, the account must be validated in order to be used for direct deposit reimbursements.

6. You may change or cancel direct deposit at any time by visiting your account online, change will take effect immediately **OR** by completing this form, checking the cancellation or change box and faxing to the number noted above. Once the form is received and processed by Meritain Health, it may take 7-10 business days before the update becomes effective.

7. If a direct deposit is returned to Meritain Health, or for any reason cannot be made to your account, Meritain Health will investigate the cause and if needed, issue a reimbursement check. Until the problem is corrected, you will continue to receive checks for any reimbursement claims paid.

8. Direct deposit services will remain in effect from one plan year to the next unless you cancel the direct deposit services.

9. Meritain Health reserves the right to automatically cancel your direct deposit services upon termination of employment or termination of your reimbursement account.

Questions? Please call Meritain Health at 1.800.566.9305, option 5.

** If the savings deposit slip does not contain a routing number maintained by your bank, you will need to submit a bank form, or statement on bank letterhead that verifies the account and routing numbers of your savings account.*

Employee / Account Holder Certification

I certify that I have read and understand the terms and conditions on this form. By signing here, I authorize my Health Reimbursement Arrangement or Flexible Spending Account reimbursements to be sent to the financial institution and account designated above. This authorization is to remain in effect until Meritain Health has been given a reasonable amount of time to act on written notification from me to terminate the deposits and continue reimbursements with mailed checks.

Employee Signature: _____ Date: _____

Joint Account Holder's Signature: _____ Date: _____

Note: Any joint account holder MUST sign this form in order to be reimbursed.

ENROLLMENT/CHANGE OF STATUS/WAIVER FORM

DELTA DENTAL

PLEASE KEEP A COPY FOR YOUR FILES. ***Please note that completing this form does not guarantee coverage.***

ALL GROUPS MUST COMPLETE THIS SECTION Note: Incomplete forms will be returned.

Delta Dental Group Number 10713 Sublocation Number 0005 ☐ Salaried ☐ Hourly
Effective Date _____ Date of Hire _____ OR Date of Rehire _____ ☐ Non-Union ☐ Union
Name of Employer SIHWIT - WCSED _____ Location/Department _____ ☐ Other _____
Group Contact Ciara Zambito _____ Phone 314-342-7128 Group Contact Email ciara.zambito@usi.com

EMPLOYEE / DEPENDENT / ADDITIONS / TERMINATIONS / CHANGES

Please check one of the options below:

☐ **Yes**, I want to enroll in the dental benefit plan(s) offered by Delta Dental of Illinois. (If enrolling in a dental benefit plan, please select a network below.)

☐ Delta Dental PPO/Delta Dental Premier

☐ **No**, I do not want to enroll in the dental benefit plan. *(If you are declining, please write your name below and sign at the bottom of this form.)*

Social Security Number _____ Employee's Name _____ (First Name / MI / Last Name)
Alternate ID # _____ # Hours Worked _____ Job Title _____
Mailing Address _____ (Street / City / State / Zip)
Email Address _____ Phone Number _____
Marital Status: ☐ S ☐ M ☐ Other Date of Birth ____/____/____ ☐ Male ☐ Female

REASON FOR SUBMITTING THIS FORM

☐ Initial or Open Enrollment ☐ COBRA COBRA End Date ____/____/____ ☐ Retiree
☐ Reinstatement due to: ○ Rehire ○ Loss of Other Coverage ○ Other _____
☐ Add Dependent (list below) due to:
○ Birth ○ Adoption ○ Marriage ○ Loss of Other Coverage ○ Legal Guardianship ○ Disabled Dependent
○ Military Dependent ○ Other _____ Date of Qualifying Event ____/____/____
☐ Drop Dependent (list below) due to:
○ Age ○ Death ○ Divorce ○ Other Coverage Elsewhere Date of Qualifying Event ____/____/____
☐ Termination of Employment Date ____/____/____ ☐ Covered Under Spouse Date ____/____/____
☐ Name Change (Former Name _____) ☐ Address Change

PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED

ADD	DELETE	FIRST NAME	LAST NAME (if different)	BIRTH DATE (mm/dd/yyyy)	SEX (M or F)
☐	☐	1. Spouse:			
☐	☐	2. Child:			
☐	☐	3.			
☐	☐	4.			
☐	☐	5.			

DENTAL COVERAGE DESIRED

☐ Employee Only ☐ Employee & Spouse ☐ Employee & One Child ☐ Employee & Children ☐ Entire Family
Is spouse covered under another dental plan? ☐ Yes ☐ No Other Carrier Name _____
Are dependents covered by spouse's plan? ☐ Yes ☐ No Spouse's Carrier _____
Spouse's Employer _____

I am requesting the coverage(s) I have selected above for which I am eligible under the contract issued by Delta Dental of Illinois for dental coverage and/or for vision coverage. I agree to continue membership in this program until the next open enrollment period. I certify that all the information stated on this form is complete and true to the best of my knowledge and Delta Dental of Illinois Insurance Company believing it to be true shall rely and act upon it accordingly. I authorize my employer/group to deduct from my pay and remit any required contributions for the cost of the selected coverage. This authorization is to remain in effect until Delta Dental of Illinois Insurance Company is notified in writing to the contrary.

Signature of Applicant _____ Date _____

Mail to: Eligibility Department · P.O. Box 3384 · Lisle, IL 60532 · Fax (630) 369-0384 · Email eligibility@deltadentalil.com

Enrollment/Change Form

Please print and complete <u>all</u> sections.
See instructions below.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

EMPLOYER INFORMATION: To be Completed by Employer					
Group Number **SIHWIT**	**Employer Name** WCSED	**Location Code** WCSED	**Division Code**	**Client Co Code**	**Effective Date**

EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)						
☐**ADD** ☐**TERM** ☐**CHG**	**Sex** ☐ M ☐ F	**Member ID**	**Last Name (Employee or subscriber)**	**First Name**	**M.I.**	**Date of Birth**
Social Security Number	**Home Street Address**			**City/State/Zip**		**Home Phone** ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)						
☐**A** ☐**T** ☐**C**	**Sex** ☐ M ☐ F	**Last Name (spouse)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**
☐**A** ☐**T** ☐**C**	**Sex** ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**
☐**A** ☐**T** ☐**C**	**Sex** ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**
☐**A** ☐**T** ☐**C**	**Sex** ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**
☐**A** ☐**T** ☐**C**	**Sex** ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**
☐**A** ☐**T** ☐**C**	**Sex** ☐ M ☐ F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**

Employee Signature: ________________________________ Date: ______________________

Instructions:

Employer name: Legal name of the employer.
Group Number: Provided by EyeMed or EyeMed representative.
Location code: Optional field for employers to track multiple locations.
Effective date: Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling. Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, employee address or employee phone.

Group Benefits from The Hartford

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155
(A stock insurance company)

Southern Illinois Health & Wellness Insurance Trust

Benefits Enrollment Form

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter and/or check** your coverage elections. Make sure the coverage amount that you elect includes your existing coverage amount. You may only elect and will be covered for levels of coverage included in your employer's contract.
- **Step 2:** Please **sign, date and return** this form to HR. Do not mail this form back to The Hartford's address indicated at the top of this form.

Information About You	
Employee Name:	**Employee ID (if not available, then Social Security Number):**
Date of Birth:	
Date of Hire:	

Dependent Information				**If more than 4 child(ren), attach additional sheet.**	
Spouse Name (includes domestic partner):		**Gender:**	**Spouse Date of Birth:**	**Date of Marriage or Eligible Partnership:**	
		☐ M ☐ F			
Child Name:	**Gender:**	**Date of Birth:**	**Child Name:**	**Gender:**	**Date of Birth:**
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

Name: _____

Basic Life and AD&D Insurance

If coverage amounts are based on earnings, your cost may change if your earnings change.

To calculate your monthly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x $0.1250 = $_____

Life and AD&D Benefit Amount | Rate | Monthly Cost

☐ I elect to **purchase** $20,000 of life and AD&D coverage at a monthly cost of $2.50.
☐ I **decline** to purchase life and AD&D coverage.

Voluntary Life Insurance

Your cost may change when you move into a new age category.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.0600	0.0600	0.0800	0.0900	0.1200	0.1800	0.3000	0.5200	0.8100	1.2800	2.0600	3.6100

To calculate your monthly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $_____

Life Benefit Amount | Rate | Monthly Cost

☐ I elect to **purchase** $_____ of life coverage.
☐ I **decline** to purchase life coverage.

Spouse Voluntary Life Insurance

Costs are based on your spouse's age. Your cost may change when your spouse moves into a new age category.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.0600	0.0600	0.0800	0.0900	0.1200	0.1800	0.3000	0.5200	0.8100	1.2800	2.0600	3.6100

To calculate your monthly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $_____

Life Benefit Amount | Rate | Monthly Cost

☐ I elect to **purchase** $_____of life coverage.
☐ I **decline** to purchase life coverage.

Child(ren) Voluntary Life Insurance

To calculate your monthly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x $0.2000 x _____ = $_____

Life Benefit Amount | Rate | Number of Covered Children | Monthly Cost

Name: _____

☐ I elect to **purchase** $_____ of life coverage.

☐ I **decline** to purchase life coverage.

Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you. A primary beneficiary is the beneficiary or beneficiaries that you name to receive the benefits if they are living at the time of your death. The primary beneficiaries are the first in line to receive death benefits. Contingent beneficiaries, or secondary beneficiaries, are those named to receive the insurance proceeds if no primary beneficiary is alive at the time you die.

PRIMARY BENEFICIARY

Primary Beneficiary Name:	**Social Security #:**	**Date of Birth:**	**Relationship:**	**Percentage:**
Address:				**Phone Number:**
Primary Beneficiary Name:	**Social Security #:**	**Date of Birth:**	**Relationship:**	**Percentage:**
Address:				**Phone Number:**

CONTINGENT BENEFICIARY

Contingent Beneficiary Name:	**Social Security #:**	**Date of Birth:**	**Relationship:**	**Percentage:**
Address:				**Phone Number:**
Contingent Beneficiary Name:	**Social Security #:**	**Date of Birth:**	**Relationship:**	**Percentage:**
Address:				**Phone Number:**

The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for employee life or accidental death insurance may be changed upon written request.

Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer. I understand and agree that if I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit(s) reduce at a specified age(s) stated in the policy.

Name: _____

I authorize payroll deductions from my wages to cover my cost of coverage when applicable. I understand rates and benefits may be changed by the insurer.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are required by The Hartford or by law and are not met, the policy will not be implemented and the coverage I have elected will not be in force.

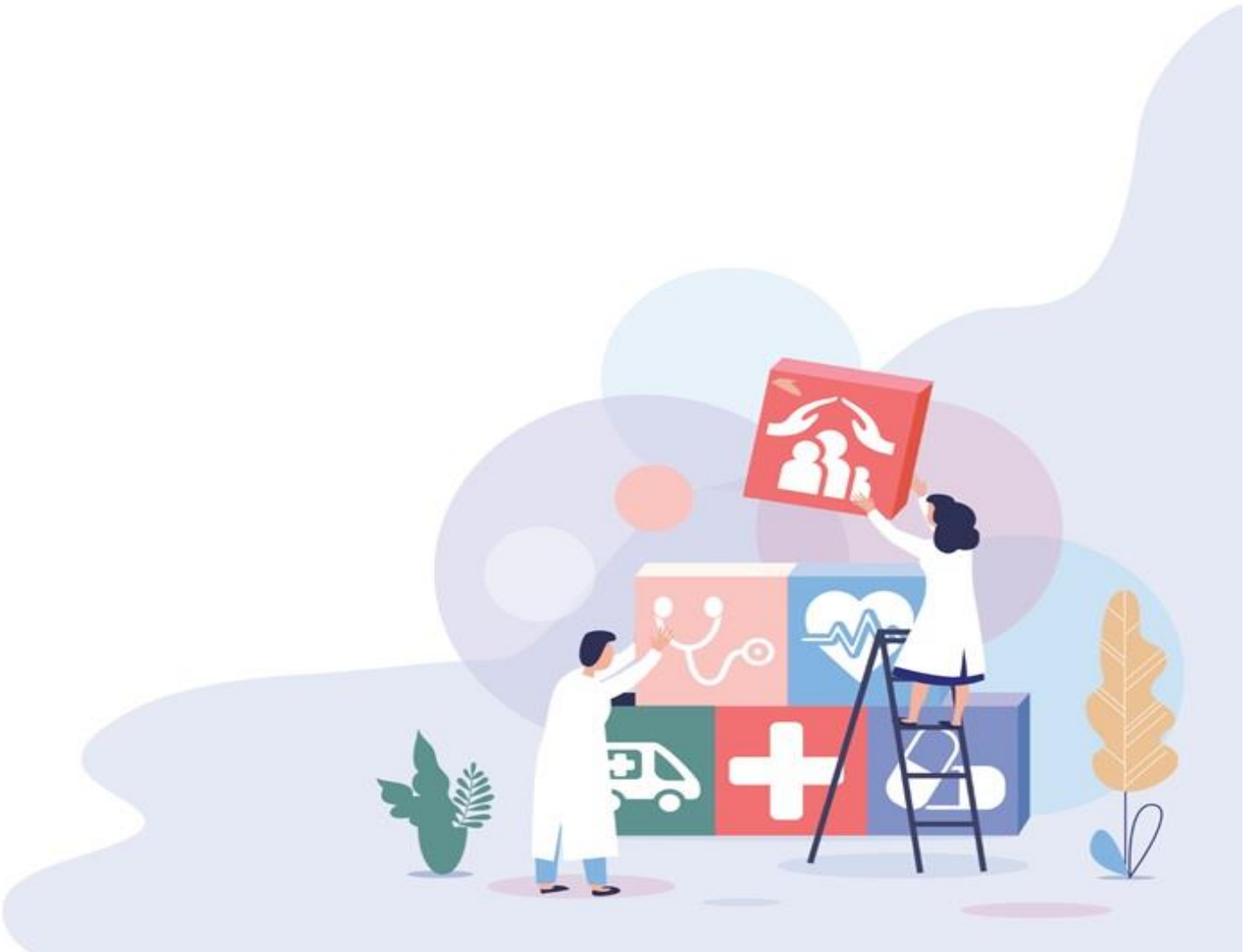
Fraud Notice(s)
For Residents of Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

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

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

Signed_____ Date_____



Required Notices

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the plans' stated deductibles and coinsurance apply.

NEWBORNS ACT DISCLOSURE - FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

NOTICE OF GRANDFATHERED STATUS

This group health plan believes the Compliant and Non-Compliant plans are “grandfathered health plans” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the contact information below. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.].

NOTICE REGARDING WELLNESS PROGRAMS

Southern Illinois Health & Wellness Insurance Trust Wellness Program is a voluntary wellness program available to all employees participating in the health insurance plans. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will be enrolled in the Compliant Health Plan for participating in the annual on-site screenings. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will be enrolled in the Compliant Health Plan.

Additional incentives may be available for employees who participate in certain health-related activities. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Southern Illinois Health & Wellness Insurance Trust may use aggregate information it collects to design a program based on identified health risks in the workplace, Southern Illinois Health & Wellness Insurance Trust will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is Marquee Health and you in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

SOUTHERN ILLINOIS HEALTH & WELLNESS INSURANCE TRUST

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligation of the Southern Illinois Health & Wellness Insurance Trust Health Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the Privacy Official at (618) 997-9201.

Effective Date

This Notice is effective January 1, 2020.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices in accordance with methods permissible under law, which may include publishing the Notice in the summary plan description or by hand-delivering the Notice to you.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; and in connection with underwriting and premium rating, subject to the prohibition and limitations on the use and disclosure of genetic information as regulated by HIPAA and the Genetic Information and Nondiscrimination Act. We may use medical information in connection with other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, information may be shared between the Plan and the Trust.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official -

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or

(2) treating such person as your personal representative could endanger you; and

(3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. We may disclose your protected health information to a spouse or other family member that is directly relevant to such person's involvement with your care or payment related to your health care. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to the Privacy Official. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Privacy Official.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Privacy Official. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Official. Your request must state a time period of no longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing to the Privacy Official. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply – for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, please contact the Privacy Official:

Privacy Official
Southern Illinois Health & Wellness Insurance Trust
411 South Court Street
Marion, Illinois 62959
Phone: (618) 997-9201

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Privacy Official:

Privacy Official
Southern Illinois Health & Wellness Insurance Trust
411 South Court Street
Marion, Illinois 62959
Phone: (618) 997-9201

All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Dated: September 17, 2019

Important Notice from Southern Illinois Health and Wellness Insurance Trust About Your Prescription Drug Coverage and Medicare

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Southern Illinois Health and Wellness Insurance Trust has determined that the prescription drug coverage offered through the Wellness Compliant Plan A, Wellness Non-Compliant Plan A and Plan B plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15thto December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Southern Illinois Health and Wellness Insurance Trust coverage will not be affected. If you joined a Medicare drug plan after a COBRA qualified event, your COBRA coverage may end.

If you do decide to join a Medicare drug plan and drop your current Southern Illinois Health and Wellness Insurance Trust coverage, be aware that you and your dependents will be able to get this coverage back.

CMS Form 10182-CC **Updated April 1, 2011**

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Southern Illinois Health and Wellness Insurance Trust and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Southern Illinois Health and Wellness Insurance Trust changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: 08/01/2022
Name of Entity/Sender: Southern Illinois Health and Wellness Insurance Trust

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MAINE-Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

RHODE ISLAND-Medicaid and CHIP	WYOMING-Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

1. Employer name Carbondale Elementary School District #95	2. Employer Identification Number (EIN) 20-2836138	
3. Employer address	4. Employer phone number	
5. City Carbondale	6. State IL	7. ZIP code
8. Who can we contact about employee health coverage at this job?		
9. Phone number (if different from above)	10. Email address	

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

- As your employer, we offer a health plan to:
  - [x] Employees as defined by Board policy and/or union contract

- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    Legal spouses and dependent children up to age 26

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

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

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

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Employer Name:	Southern Illinois Health and Wellness Insurance Trust
Employer State of Situs:	**Illinois**
Name of Issuer:	**Meritain**
Plan Marketing Name:	**Compliant / Non-Compliant / MVP Plan**
Plan Year:	**September 1, 2022 – August 31, 2023**

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2022 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	No
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	No
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes

22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	–
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	No
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this disclosure is not a guarantee of benefits.