YOUR **BENEFITS** YOUR **CHOICES**

Berlin Area School District

2023

BENEFITS GUIDE SUPPORT STAFF

BENEFITS ENROLLMENT CHECKLIST

This guide will help you get to know your benefits and your choices for the 2023 plan year. Be sure to learn about your options so you can make informed choices for yourself and your eligible dependents.

IN THE FIRST 30 DAYS

Enroll in these plans or waive coverage:

- ☐ Medical
- ☐ HRA & HSA
- ☐ Dental
- ☐ Vision
- ☐ Flexible Spending Account
- ☐ Long Term Disability
- ☐ Short Term Disability
- ☐ Life
- ☐ Voluntary Life

MEDICAL PLANS

MEDICAL PLANS

You get the most from your benefits when you take the time to learn about your options and make decisions that are best for you and your family. Berlin Area School District provides eligible employees the choice of two medical plans administered by Wisconsin Counties Association (WCA) /Group Health Trust (GHT) with claims processed by UMR.

You have access to providers participating in the UHC Choice Plus network. Find a participating health care provider in your area by going to: UMR.com.

Refer to the Summary Plan Descriptions (SPDs) or Summary of Benefits Coverage (SBCs) for detailed medical plan coverage information.

WHO IS ELIGIBLE FOR BENEFITS

- All full-time who work 30 hours or more per week.
- Your spouse.
- Your biological children, stepchildren, legally adopted children (effective from the date place for adoption), and foster children up to age 26.

TERMS TO KNOW

Annual Deductible
The amount you pay out of your pocket each year before the plan begins sharing costs for most services. Payments to in-network and out-of-network providers count toward your annual deductible and annual out-of-pocket maximum.

Copay
The dollar amount you must pay for certain covered services. Payments count toward your annual out-of-pocket maximum but do not count toward your deductible.

Annual Out-of-Pocket Maximum
The most you'll have to pay out of your pocket in a calendar year for covered services.

Coinsurance
The cost share between you and the plan after you meet the calendar year deductible. In other words, after you meet your deductible, you share any remaining covered expenses with the plan. The plan covers the percentage of the expense shown.

MEDICAL PLAN HIGHLIGHTS – *WCA Plan Options*

General Plan Information	WCA Group Health Plan HRA Plan Embedded $3,000 / $6,000		WCA Group Health Plan HSA Plan Embedded $3,000 / $6,000	
	In-Network	***Out-Of-Network***	***In-Network***	***Out-Of-Network***
Network	UHC Choice Plus	N/A	UHC Choice Plus	N/A
Deductible – Calendar Year	Single: $3,000 Family: $6,000	N/A	Single: $3,000 Family: $6,000	N/A
Coinsurance	80/20%	N/A	90/10%	N/A
Out-of-Pocket Maximum	Single: $4,500 Family: $9,000	N/A	Single: $4,500 Family: $9,000	N/A
Dependent Eligibility	To Age 26 (End of Month)		To Age 26 (End of Month)	
Physician Services				
Office Visits - Primary Care	$25	N/A	Deductible Applies	N/A
Office Visits - Specialty Care	$50	N/A	Deductible Applies	N/A
Preventive Care	100% Selected Services	N/A	100% Selected Services	N/A
Hospital Services				
Inpatient	Deductible Applies	N/A	Deductible Applies	N/A
Outpatient	Deductible Applies	N/A	Deductible Applies	N/A
Emergency and Urgent Care				
Emergency Room	$250 Copay		Deductible Applies	
Urgent Care/Walk-in Clinic	$75 Copay		Deductible Applies	
Prescription Drugs				
Retail	$0 / $10 / $25 / $60 / $150		Deductible Applies	
Rx Out-of-Pocket Maximum	$2,000 / $4,000		Included in Medical OOP Max	

HEALTH REIMBURSEMENT ACCOUNT (HRA)

HRAs are being implemented by many employers to help manage increasing health care costs and to provide employees with an incentive to be better consumers of health care. If you are enrolled in the Medical Plan – HRA Plan, Berlin Area School District HRA covers a portion of the deductible as follows:

- Member meets the first $500 single / $1,000 family deductible.
- The HRA will then cover the next $500 single / $1,000 family.
- The Member then pays the remaining $2,000 Single / $4,000 Family deductible.

Your employer is working with DBS to manage and administer the HRA.

The program works as follows:

- You and/or your family members utilize your health plan as you normally would. When you use your health plan, the insurance company will process your claim and send an Explanation of Benefits form (EOB) to you. The EOB form shows the date of service, service provided, cost of the service, and the amount insurance paid on the claim.

- After you've paid your up-front deductible, the HRA will then automatically pay the next portion of the eligible deductible.

- The deductible amounts will be paid directly to the vendor/provider based on your employer's HRA reimbursement plan parameters.

- Create your online account with DBS to review claims and payments as they are processed.

- There are no claim forms to file for the HRA. (However, if you have dual health coverage, you must manually submit EOB forms from the secondary insurance carrier along with a signed claim form for reimbursement.)

- The plan follows the health insurance plan year July 1 through June 30.

HEALTH SAVINGS ACCOUNT (HSA)

Berlin Area School District offers a medical plan that features an HSA – the High Deductible Health Plan. An HSA allows the money to go in tax-free, earns interest tax free and can be spent on qualified health care expenses tax-free.

If you are enrolled in the High Deductible Health Plan option, you may open an HSA account with your choice between two local banks. The Berlin Area School District will contribute $500 Single / $1,000 Family into your HSA.

HOW THE HSA WORKS

MONEY GOES IN	Pretax contributions* from you, up to a total of: ○ $3,850 for individual coverage ○ $7,750 if you enroll your spouse and/or child(ren). ○ An extra $1,000 if you are age 55 or older
MONEY GOES OUT	You pay the full cost of non-preventive care, including non-preventive prescription drugs, until you meet the deductible. You receive discounted rates in-network. When you have an eligible health care expense, **you decide whether to use your HSA if you've accumulated enough money to cover it or pay with other resources. Either way, those dollars count toward the medical plans' deductible and out-of-pocket maximum. Any amount you spend on qualified medical expenses is also tax-free.
HAVE MONEY LEFT? IT ROLLS OVER!	Any money left in your account is yours to pay for health care in the future. There's no deadline and no limit on how large your account can grow. If you leave Berlin Area School District, you can take it with you.

**If you're enrolling during the year, you may not be eligible to make a full-year contribution to your HSA. Talk to your tax advisor before signing up for pretax deductions. See IRS Publication 969 for more information.*
*** The HSA can be used to reimburse you for qualified medical, dental, and vision expenses. See IRS Publication 502 for more information.*

You Are Eligible To Open An HSA If…

- You are enrolled in the High Deductible Health Plan.
- You do not have other non-qualified group health coverage.
- Neither you nor your spouse is currently enrolled in Medicare or TRICARE
- You are not claimed as a dependent on another person's tax return.
- You have not received VA medical benefits at any time during the past three months

FLEXIBLE SPENDING ACCOUNTS (FSA)

With an FSA, you can set aside tax-free money to pay for eligible medical and dependent care expenses. When you participate in an FSA, you decide how much you want to contribute each plan year (Jan. 1 through Dec. 31). The money you contribute is deducted from your pay before taxes are taken out. ***This lowers your taxable income, which means lower taxes for you!*** However, you must use the amounts in your account by year-end or lose the balance.

Berlin Area School District offers three types of FSAs administered by DBS.

TRADITIONAL HEALTH CARE FSA

You can use this FSA to pay any qualified health care expense, including copays and deductibles, dental care and vision care. Please see DBS website http://www.dbsbenefits.com for detailed list of qualified healthcare expenses.

- Annual Maximum Healthcare election is $3,050 for 2023.
- Your FSA plan allows you to carry over unused funds into the following plan year. You can carryover $610 for the 2023 plan year into the 2024 plan year.

You're ***not*** eligible for the Traditional Health Care FSA if you're enrolled in the HSA Qualified Plan option.

LIMITED HEALTH CARE FSA

Employees who enroll in the Qualified High Deductible Health Plan with HSA can only enroll in a limited FSA plan. This plan can be used for out of pocket **dental and vision expenses only**.

- Annual Maximum Limited Flex Plan election is $3,050 for 2023.
- Your FSA plan allows you to carry over unused funds into the following plan year. You can carryover $610 for the 2023 plan year into the 2024 plan year.

DEPENDENT CARE FSA

The Dependent Care FSA covers the eligible day care expenses for your tax-qualified dependent(s). This can include a tax-qualified dependent under the age of 13 or an elderly parent or spouse who is physically or mentally incapable of self-care and lives with the account owner.

Unmarried individuals and married couples who file a joint tax return can contribute up to a maximum of $5,000 per year. Individuals who are married and file taxes separately can contribute up to a maximum of $2,500. You can't contribute more than you or your spouse earned in income for the year. ***If you're enrolling during the year, you may not be eligible to make the maximum contribution to your FSAs. Talk to your tax advisor before signing up for pretax deductions. See IRS Publication 502 for more information.***

DENTAL PLANS

Berlin Area School District offers two dental plan options through Delta Dental for all eligible employees. With one of the nation's largest networks, you're virtually guaranteed to find a choice of pre-screened, in-network dentists within minutes of your home or workplace. You can easily find a dentist using our web site or mobile app.

But choice of providers is just one reason to go with Delta Dental. You will also enjoy discounts on care; and a range of time-saving special features such as the ability to locate an in-network provider via your smart phone.

Most importantly, Delta Dental Insurance provides sweeping coverage for the full range of dental services – routine checkups, x-rays, cleanings, fillings, dental implants, adult fluoride treatments, and oral cancer screenings.

Save Money by Staying in the Network
You may seek dental care from any provider; however, your out-of-pocket expenses will be greatly reduced if care is provided by a dentist in the Delta Dental network. For more details or to find a provider in the network, visit www.deltadentalwi.com or call 1-800-236-3712.

Evidence Based Integrated Care
Your dental plan includes Evidence-Based Integrated Care Plan, which offers additional cleanings and fluoride treatment for certain medical conditions, such as periodontal disease, heart disease, diabetes, and cancer-related treatments. You will need to self-register for the benefit by calling Delta Dental's customer service team, or you can register on the member portal. It's very simple to enroll, and proof of condition is not required.

Check Up Plus
Your dental plan also includes a feature called Check Up Plus. With Check Up Plus, diagnostic and preventive services don't count against your individual annual maximum! So, you will have more of your annual maximum available if you do need basic and/or restorative care.

Benefit Plan Design – Low Plan	Delta Dental PPO	Delta Dental Premier	Non-Contracted Dentist
Individual Annual Maximum	$1,000	$1,000	$1,000
Deductible	$0 / $0	$0 / $0	$0 / $0
Diagnostic & Preventive Services 2 Exams, 2 Cleanings, Fluoride Treatments, X-rays, Sealants	100%	100%	100%
Basic & Major Services Emergency Treatment, Fillings, Simple Extractions, Oral Surgery, Root Canals, Gum Disease Treatment	100%	90%	80%
Major Restorative Services Inlays, Onlays, Crowns, Bridges, Dentures, Implants, Repairs & Adjustments to Bridges & Dentures	70%	60%	50%
Orthodontic Services Children to age 19	50% $1,500 Lifetime Maximum	50% $1,500 Lifetime Maximum	50% $1,500 Lifetime Maximum

DENTAL PLANS

Benefit Plan Design – High Plan	Delta Dental PPO	Delta Dental Premier	Non-Contracted Dentist
Individual Annual Maximum	$5,000	$5,000	$5,000
Deductible	$25 / $75	$25 / $75	$25 / $75
Diagnostic & Preventive Services 2 Exams, 2 Cleanings, Fluoride Treatments, X-rays, Sealants	100%	100%	80%
Basic & Major Services Emergency Treatment, Fillings, Simple Extractions, Oral Surgery, Root Canals, Gum Disease Treatment	100%	90%	50%
Major Restorative Services Inlays, Onlays, Crowns, Bridges, Dentures, Implants, Repairs & Adjustments to Bridges & Dentures	100%	90%	50%
Orthodontic Services Dependents to age 26 and Adults	100% $2,000 Lifetime Maximum	100% $2,000 Lifetime Maximum	50% $2,000 Lifetime Maximum

For additional information, refer to the Benefit Summaries provided by Delta Dental.

DELTA DENTAL VALUE ADD PROGRAMS

Vision Care Discount
Delta Dental of Wisconsin has partnered with EyeMed Vision Care, to offer you savings on optical costs (up to 35%), with access to thousands of private practice and retail providers nationwide.*

Amplifon Hearing Discount
Delta Dental has partnered with Amplifon to provided member with resources for hearing aids, including access to an
Amplifon Hearing Health Care discount card, custom hearing solutions, continuous care, and a risk-free 60 day trial. *

*Please see attached flyers for more information.

VISION PLAN

The Berlin Area School District offers a voluntary vision plan through VSP.

SERVICES	IN-NETWORK
FREQUENCY	
Eye Exam	Once per 12 months
Lenses	Once per 12 months
Frames	Once per 24 months
Contact Lenses	Once per 12 months
VISION BENEFITS	
Vision Examination	$20 copay then 100%
Retail Frames	$20 copay with $150 allowance
Retail Frame Discount	*20% off amount over allowance*
***LENS BENEFIT**	***$20 Copayment Then***
Single Vision	100%
Lined Bifocal	100%
Lined Trifocal	100%
CONTACT LENSES	
Lens Fitting/Evaluation	Covered in lieu of lenses & frame benefit
Lieu of Glasses	$130 allowance

Subject to certain exclusions & limitations

For additional information, refer to the Benefit Summary provided by Vision Service Plan Ins. Co.

PREMIUM CONTRIBUTIONS

School Year Support Staff Health Insurance Responsibility for 2023-24

HEALTH INSURANCE - Per paycheck Premiums (19)

	HRA - without health assessment		HRA - with health assessment	
Hours	**Single**	**Family**	**Single**	**Family**
6	$280.03	$634.15	$267.59	$605.97
6.25	$261.36	$591.88	$248.92	$563.69
6.5	$248.92	$563.69	$236.47	$535.51
6.75	$236.47	$535.51	$224.03	$507.32
7	$217.80	$493.23	$205.36	$465.05
7.25	$199.13	$450.95	$186.69	$422.77
7.5	$186.69	$422.77	$174.24	$394.58
7.75	$174.24	$394.58	$161.80	$366.40
8	$155.57	$352.31	$143.13	$324.12

	HSA - without health assessment		HSA - with health assessment	
Hours	**Single**	**Family**	**Single**	**Family**
6	$268.02	$606.91	$256.10	$579.94
6.25	$250.15	$566.45	$238.24	$539.48
6.5	$238.24	$539.48	$226.32	$512.51
6.75	$226.32	$512.51	$214.41	$485.53
7	$208.46	$472.04	$196.55	$445.07
7.25	$190.59	$431.58	$178.68	$404.61
7.5	$178.68	$404.61	$166.77	$377.64
7.75	$166.77	$377.64	$154.85	$350.66
8	$148.90	$337.17	$136.99	$310.20

PREMIUM CONTRIBUTIONS

Calendar Year Support Staff Health Insurance Responsibility for 2023-24

HEALTH INSURANCE MONTHLY PREMIUMS	Without Health Assessment	With 2% Discount with Health Assessment
HRA Single 14 or 12%	$137.94	$118.24
HRA Family 14 or 12%	$312.38	$267.75
HSA Single 10 or 8%	$94.30	$75.44
HSA Family 10 or 8%	$213.54	$170.84

Calendar Year Support Staff Only

DENTAL INSURANCE MONTHLY PREMIUMS	Low Plan	High Plan
Single	$3.46	$17.12
Family	$10.12	$45.76

School Year & Calendar Year Support Staff

VISION INSURANCE MONTHLY PREMIUMS	
Employee Only	$5.77
Employee & Spouse	$9.24
Employee & Child(ren)	$9.43
Family	$15.21

THE STANDARD BENEFITS

VOLUNTARY SHORT TERM DISABILITY (STD)

Short Term Disability (STD) is offered through Standard Insurance Company. The voluntary STD plan pays a percentage of your salary if you become temporarily disabled, meaning that you are not able to work for a short period of time due to sickness or injury.

Benefits begin on the 1 day for an injury and on the 4 day for sickness. You have two plan options to chose from.

- Benefit Option 1, the benefit will provide up to 66 2/3% of your weekly earnings to a maximum of $500 for up to 60 days.
- Benefit Option 2, the benefit will provide up to 66 2/3% of your weekly earnings to a maximum of $1,000 for up to 60 days.

Use this formula to calculate your premium payment:

______________	x 0.6667 x	______________	÷ 10 =	______________
Enter your weekly earnings (cannot be more than $750 for Option 1 or $1,500 for Option 2).		Enter your rate from the rate table.		This amount is an estimate of how much you'd pay each month.

Plan Options	Rate per $10 of weekly benefit
Option 1	$0.69
Option 2	$0.66

LONG TERM DISABILTIY (LTD)

The Standard Insurance Company Long Term Disability plan benefits help provide you with monthly income if you become disabled and are unable to work.

For all eligible employees, after you have been disabled for 60 days due to sickness or injury, this benefit will provide up to 66 2/3% of your monthly earnings to a maximum of $10,500. If you are permanently disabled, you will receive this benefit up to your Social Security Normal Retirement Age (SSNRA). Rates are based on your age.

NOTE: *Both the STD and LTD include pre-existing condition limitations. Please review the plan summaries for more details. Earnings for STD and LTD benefits are based on your base annual earnings and do not include other income such as bonuses and commissions. Please see plan documents for eligibility parameters for both STD and LTD..*

THE STANDARD BENEFITS *(continued)*

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

Life Insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump payment if you pass away while employed by Berlin Area School District. As an eligible employee, you are covered for Basic Life and AD&D insurance at no cost to you.

Berlin Area School District offers a Group Term Life Insurance benefit of 1.5 times your annual earnings plus Accidental Death and Dismemberment insurance coverage.

Specific details of the plan are covered in the Employee Life Benefit Plan Certificate. Please see plan documents for eligibility parameters.

GROUP TERM LIFE AND AD&D

Premium	Berlin Area School District pays this premium at 100%
Amount of Life Insurance Benefit	1.5 times your annual earnings to a maximum of $300,000
Amount of AD&D Benefit	Equal to term life

SUPPLEMENTAL LIFE INSURANCE

In addition to the Basic Life and AD&D insurance provided to you by Berlin Area School District, you also have the option to purchase Supplemental Life Insurance coverage for yourself. Employees must be working at least a minimum number of hours that your employer deems an eligible hourly (30 hours) per week.

- Employee: up to $500,000 additional life benefit; $80,000 Guarantee Issue
- Spouse: up to $250,000; $25,000 Guarantee Issue
- Child(ren): $5,000 benefit

Please see a representative from HR with any questions.

EMPLOYEE ASSISTANCE PROGRAM (EAP)*

You, your dependents (including children to age 26) and all household members can contact master's- degreed clinicians 24/7 by phone, online, live chat, email and text. There's even a mobile EAP app. Receive referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services. Your program includes up to three face-to-face assessment and counseling sessions per issue. EAP services can help with:

- ☐ Depression, grief, loss and emotional well-being
- ☐ Family, marital and other relationship issues
- ☐ Life improvement and goal-setting
- ☐ Addictions such as alcohol and drug abuse
- ☐ Stress or anxiety with work or family
- ☐ Financial and legal concerns
- ☐ Identity theft and fraud resolution

LIFE SERVICES

Life Services Toolkit website:

- ☐ Estate-planning Assistance: Online tools walk employees through the steps to prepare a will and create other documents, such as living wills, powers of attorney and healthcare agent forms.
- ☐ Identity Theft Prevention: Online resources help employees learn how to thwart identity thieves and resolve issues if identity theft occurs.
- ☐ Financial Planning: Online tools help employees confidently manage debt, calculate mortgage and loan payments, and take care of other financial matters.
- ☐ Health and Wellness: Timely articles about nutrition, stress management and wellness help employees and their families lead healthy lives.
- ☐ Funeral Arrangements: Employees can use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

TRAVEL ASSISTANCE*

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip.

**Flyers Attached*

TheStandard
A helping hand when you need it.
Rely on the support, guidance and resources of your Employee Assistance Program.
Standard Insurance Company

There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program,[1] which includes WorkLife Services and is available to you and your family in connection with your group insurance from Standard Insurance Company (The Standard). It's confidential — information will be released only with your permission or as required by law.

Connection to Resources, Support and Guidance

You, your dependents (including children to age 26)[2] and all household members can contact master's-degreed clinicians 24/7 by phone, online, live chat, email and text. There's even a mobile EAP app. Receive referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

Your program includes up to three assessment and counseling sessions per issue. Sessions can be done in person, on the phone or by video.

EAP services can help with:

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation

WorkLife Services

WorkLife Services are included with the Employee Assistance Program. Get help with referrals for important needs like education, adoption, travel, daily living and care for your pet, child or elderly loved one.

Online Resources

Visit **workhealthlife.com/Standard3** to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

With EAP, assistance is immediate, personal and available when you need it.

Contact **EAP**

888.293.6948
TDD: 800.327.1833
24 hours a day,
seven days a week

workhealthlife.com/Standard3

NOTE: It's a violation of your company's contract to share this information with individuals who are not eligible for this service.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

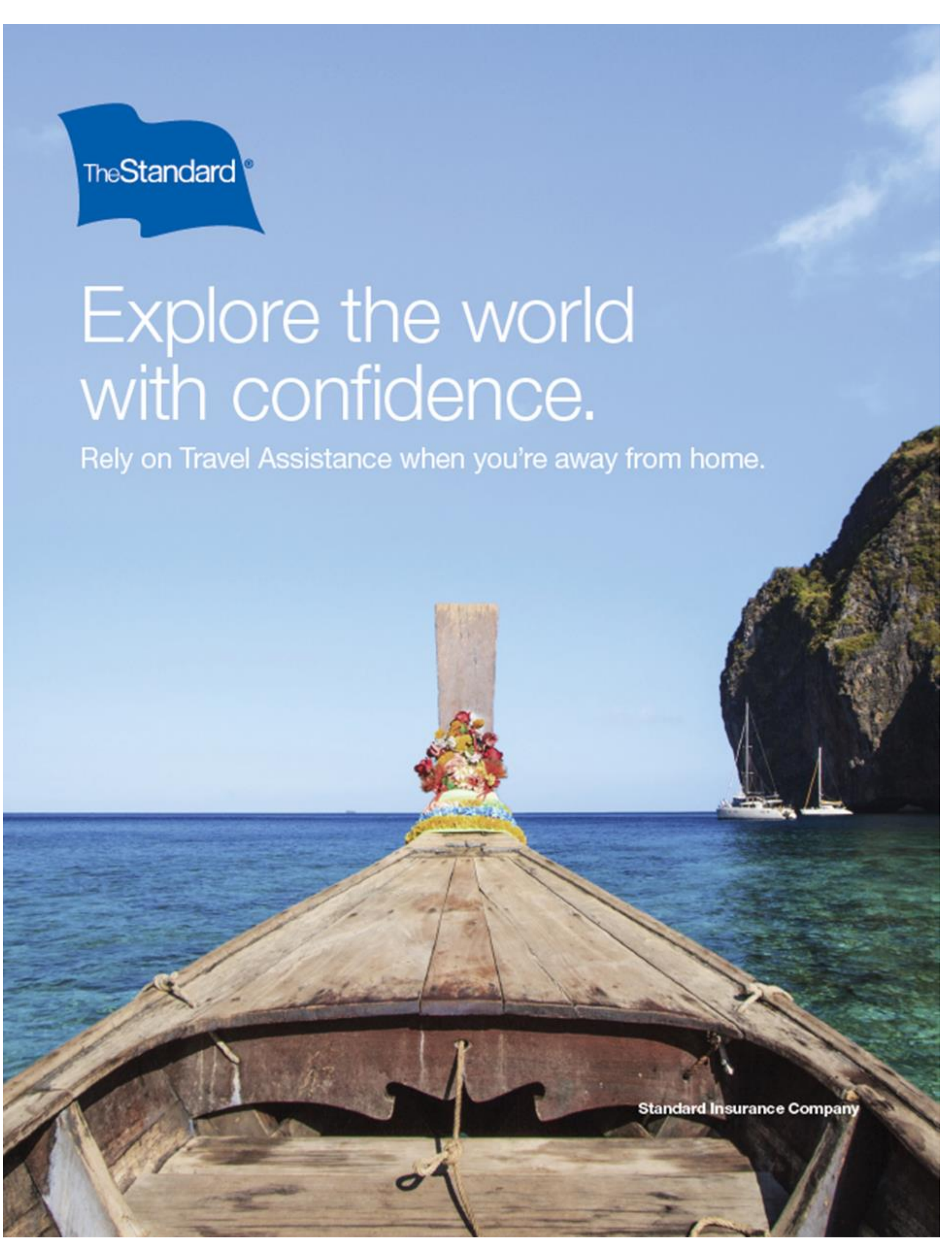
1 The EAP service is provided through an arrangement with Morneau Shepell, which is not affiliated with The Standard. Morneau Shepell is solely responsible for providing and administering the included service. EAP is not an insurance product and is provided to groups of 10–2,499 lives. This service is only available while insured under The Standard's group policy.

2 Individual EAP counseling sessions are available to eligible participants 16 years and older; family sessions are available for eligible members 12 years and older, and their parent or guardian. Children under the age of 12 will not receive individual counseling sessions.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

SI **17201**

Employee Assistance Program-3 EE
(5/20)



TheStandard®
Explore the world with confidence.
Rely on Travel Assistance when you're away from home.
Standard Insurance Company

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night.[1]

You and your spouse are covered with Travel Assistance — and so are kids through age 25 — with your group insurance from Standard Insurance Company (The Standard).[2]

Security That Travels with You

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

Visa, weather and currency exchange information, health inoculation recommendations, country-specific details and security and travel advisories

Credit card and passport replacement and missing baggage and emergency cash coordination

Help replacing prescription medication or lost corrective lenses and advancing funds for hospital admission

Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains[3]

Connection to medical care providers, interpreter services, local attorneys and assistance in coordinating a bail bond

Return travel companion if travel is disrupted due to emergency transportation services or care of minor children if left unattended due to prolonged hospitalization

Assistance with the return of your personal vehicle if your emergency transportation services leave it stranded

Evacuation arrangements in the event of a natural disaster, political unrest and social instability

Contact Travel Assistance

800.872.1414
United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda

Everywhere else
+1.609.986.1234

Text:
+1.609.334.0807

Email:
medservices@assistamerica.com

Get the App

Get the most out of Travel Assistance with the Assist America Mobile App.

Click one of the links below or scan the QR code to download the app. Enter your reference number and name to set up your account. From there, you can use valuable travel resources including:

- One-touch access to Assist America's Emergency Operations Center
- Worldwide travel alerts
- Mobile ID card
- Embassy locator

Reference Number:
01-AA-STD-5201

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

1 Travel Assistance is provided through an arrangement with Assist America, Inc. and is not affiliated with The Standard. Travel Assistance is subject to the terms and conditions, including exclusions and limitations of the Travel Assistance Program Description. Assist America, Inc. is solely responsible for providing and administering the included service. Travel Assistance is not an insurance product. This service is only available while insured under The Standard's group policy.

2 Spouses and children traveling on business for their employers are not eligible to access these services during those trips.

3 Must be arranged by Assist America, Inc.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

SI 14694

Travel Assistance EE
(6/20)

DELTA DENTAL

Vision Care Discount

Your dental plan from Delta Dental comes with a **free** Vision Discount Program.

Delta Dental of Wisconsin has chosen EyeMed Vision Care® as the network provider for your vision care discount program. This is not insurance, but a discount plan that provides:

- Overall savings up to 35 percent.
- Access to thousands of private practice and retail providers nationwide, including LensCrafters®, Sears Optical®, Target Optical®, Shopko Optical®, and most Pearle Vision® locations.
- Choice of any product, including designer brand-name frames (certain brands impose a no-discount policy and the frame discount is not available).
- Savings on laser vision correction.
- Replacement contact lenses by mail.

accessing your benefits

Receiving your vision care discount is easy. Simply:

1. Locate an EyeMed Vision Care provider using the provider search on our website at **www.deltadentalwi.com/provider-search/vision**, or by calling EyeMed at **866-246-9041** (toll-free).
2. When scheduling your appointment, inform the office that you are an EyeMed member with a Delta Dental discount plan.
3. When you arrive for your appointment, present the enrollee card below to receive services.

This is a discount plan. It is not insurance. This discount plan may not be combined with any other discounts, promotional offers, or insurance coverage, and does not apply to EyeMed provider's professional services, or contact lenses.

Vision Care Discount Program Enrollee Cards

(Please detach cards for use)

DELTA DENTAL

EyeMed Group Number: 9231093
Group Name: Delta Dental Vision Discount Program
Member Name: ....

For provider information, go to www.deltadentalwi.com/provider-search/vision, or call EyeMed Vision Care at 866-246-9041.

This is a discount plan. It is NOT insurance.

DELTA DENTAL

EyeMed Group Number: 9231093
Group Name: Delta Dental Vision Discount Program
Member Name: ....

For provider information, go to www.deltadentalwi.com/provider-search/vision, or call EyeMed Vision Care at 866-246-9041.

This is a discount plan. It is NOT insurance.

Vision Discount Program	Member Benefit
Exam (with dilation as necessary)	$5 off comprehensive exam/ $5 off contact-lens exam
Complete Pair of Glasses The following discounts and fees for frames, lenses, and lens options apply only if a complete pair is purchased in the same transaction. Items purchased separately will be discounted 20% off of the retail price.	
Frames (any frame available at provider location)	35% off retail price
Single Plastic Lenses (including standard scratch coating)	Member Pays:
Single-Vision	$50
Bifocal	$70
Trifocal	$105
Lens Options	Member Pays:
UV Coating	$15
Tint (solid and gradient)	$15
Standard Polycarbonate	$40
Standard Anti-Reflective Coating	$45
Standard Progressive (add-on to bifocal)	$65
Conventional Contact Lenses (materials only)	15% off retail price
Laser Vision Correction (LASIK or PRK)	15% off retail price or 5% off promotional price
Frequency (Exams, frames, lenses, and contact lenses)	Unlimited

additional notes

- After initial purchase, replacement contact lenses may be obtained online at substantial savings and mailed directly to the member. Details are available at **www.eyemedvisioncare.com/deltadental**.
- Members will receive 20 percent discount on items purchased at participating providers not included under the program. Twenty percent discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider's professional services, or contact lenses.
- Retail prices may vary by location.

plan limitations/exclusions:

- Orthoptic or vision training, subnormal vision aids, and associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear
- Services provided as a result of any Worker's Compensation law
- Plano non-prescription lenses and non-prescription sunglasses (except for 20 percent discount)

SS325-1606

Vision Care Discount Program Enrollee Cards

(Please detach cards for use)

Members: Locate an EyeMed provider convenient to you at:

www.deltadentalwi.com/provider-search/vision

866-246-9041

When scheduling an appointment, inform the provider that you have a vision discount plan through the EyeMed Access panel of providers, with Delta Dental of Wisconsin.

At the time of your appointment, remind the provider that you have a vision discount plan through the EyeMed Access Plan.

Providers: This is NOT insurance - it is a vision discount plan.

Members: Locate an EyeMed provider convenient to you at:

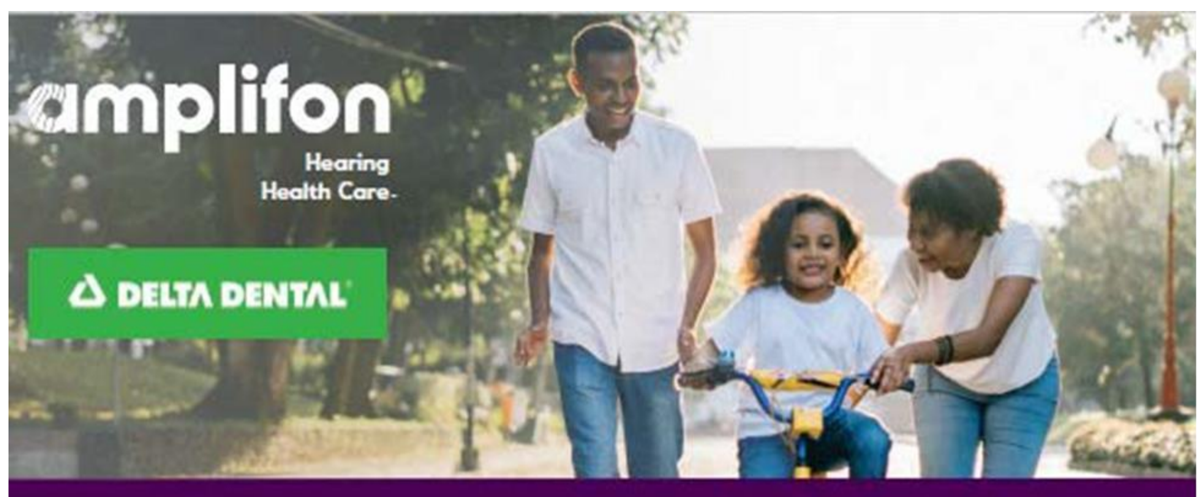
www.deltadentalwi.com/provider-search/vision

866-246-9041

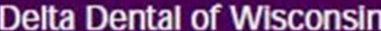
When scheduling an appointment, inform the provider that you have a vision discount plan through the EyeMed Access panel of providers, with Delta Dental of Wisconsin.

At the time of your appointment, remind the provider that you have a vision discount plan through the EyeMed Access Plan.

Providers: This is NOT insurance - it is a vision discount plan.



YOUR HEARING HEALTH CARE PROGRAM FOR LIFE



Delta Dental of Wisconsin

CUSTOM HEARING SOLUTIONS

We find the solution that best fits your lifestyle and your budget from one of our 10 brands.

RISK-FREE 60-DAY TRIAL

100% money-back guarantee if not completely satisfied. No restocking or return fees.

CONTINUOUS CARE

1-year free follow-up care, 2 years free batteries, and a 3-year warranty.*

HEARING AID LOW-PRICE GUARANTEE**

If you find the same product at a lower price, bring us the local quote and we'll not only match it, we'll beat it by 5%.

ACCESSING YOUR DISCOUNT

IS AS EASY AS...

Call Amplifon at **1-888-901-0132** and we'll find a provider near you

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

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

www.amplifonusa.com/deltadentalWI

ADDITIONAL MONEY-SAVING OFFER!*

CALL TODAY: 1-888-901-0132

*Savings on top of our already discounted pricing.
Please bring this offer with you to your appointment.

$50 off one hearing aid OR **$125** off two hearing aids

Amplifon offers a price match on most hearing devices. Some exclusions apply. Not available where prohibited by law. Visit amplifonusa.com or call for more details.

*Some exclusions apply. Limited to one-time claim for loss and damage. Deductibles may apply.

**Amplifon offers a price match on most hearing devices. Some exclusions apply. Not available where prohibited by law. Visit amplifonusa.com or call for more details.

Hearing services are administered by Amplifon Hearing Health Care, Corp. Amplifon Hearing Health Care is solely responsible for the administration of hearing health care services, and its own financial and contractual obligations. Delta Dental of Wisconsin and Amplifon are independent, unaffiliated companies.

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Delta Dental is a Registered Mark of Delta Dental Plans Association.

DELTA DENTAL

Smarter Dental Plans

Enhanced dental benefits for those who need them most.

Your dental coverage includes Delta Dental of Wisconsin's Evidence-Based Integrated Care Plan (EBICP), which provides **additional cleaning(s) and/or fluoride treatments to individuals with specific medical conditions** that have oral health implications. Enhanced benefits can play an important role in the management of certain medical conditions.

If you or an individual on your plan have one or more of these conditions, you can enroll online. Once you enroll, you are immediately eligible for EBICP benefits.

how to enroll

1. Go to **www.deltadentalwi.com**.
2. Select the purple "Sign In" button and enter your Username & Password.
3. On your dashboard under "Preventive Care and Plan Features" there will be a section for Additional Benefits. Select "Enroll Now."*
4. In the "Enroll in EBICP" section, select the member and their condition, verify the information, and hit "Select."
5. This member will then be listed under "Your Current EBICP Benefits."

Condition	Additional cleaning(s)	Topical fluoride
Cancer-related treatments	✓	✓
Weakened immune systems	✓	✓
Periodontal (gum) disease*	✓	✓
High-risk cardiac conditions	✓	
Kidney failure or dialysis	✓	
Diabetes	✓	
Pregnancy	✓	

This chart provides a brief summary of additional benefits to persons enrolled in EBICP. Frequency limitations may apply. Refer to your handbook.

**Periodontal cleanings may fall under basic services and may not be covered 100% by the EBICP plan. If you have questions regarding coverage for periodontal cleanings, please contact the Benefit Center at 800-236-3712 before services are performed.*

WHO TO CONTACT

Coverage	Carrier	Contact Information	
Medical	WCA Group Health Trust	Wcaght.org	866.404.2700
Prescription Drug	CVS		866.818.6911
Dental	Delta Dental	DeltaDentalWI.com	800.236.3712
Vision	VSP	VSP.com	800.877.7195
FSA & HRA	DBS	DBSbenefits.com	800.234.1229
Life and Disability	Standard	Standard.com	888.937.4783
Employee Assistance Program	Standard	www.eapbda.com	888.293.6948
Travel Assistance	Assist America	assistamerica.com	800.872.1414

This guide summarizes the key features of the Berlin Area School District benefit plans. This guide is not a plan document or summary plan description for any benefit plan, and it does not amend the plan documents or summary plan descriptions in any way. Please refer to the plan documents for exact terms and conditions of coverage. If any information in this guide conflicts with information in the official plan documents, the terms of the plan documents will govern in all cases. Berlin Area School District and its affiliated entities reserve the right to change, modify or terminate the benefit plans at any time and for any reason. This guide does not constitute a contract of employment between Berlin Area School District and any individual, or an obligation by Berlin Area School District to maintain any particular benefit program, practice or policy or make any benefit payment.

REQUIRED FEDERAL NOTICES

HIPAA 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 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).

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 [insert “30 days'' or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Tricia Polakowski.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

If WHCRA applies to you and if you are receiving benefits in connection with a mastectomy and you elect breast reconstruction, coverage must be provided for

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses (e.g., breast implant); and
- Treatment for physical complications of the mastectomy, including lymphedema.

Contact your state's insurance department to find out about whether protections in addition to WHCRA will apply to your coverage if you are NOT in a self-insured health plan.

The WHCRA requires group health plans and health insurance issuers, including insurance companies and health maintenance organizations (HMOs), to notify individuals regarding coverage required under the law. Notification is required at three separate times

1. After enactment of WHCRA
2. Upon enrollment
3. Annually

For further information about WHCRA or to ask questions about how it relates to your specific circumstances, you can e-mail us at phig@cms.hhs.gov. Or you may call us at 1-877-267-2323, ext. 61565.

http://www.cms.hhs.gov/healthinsreformforconsume/06_thewomen%27shealthandcancerrightsact.asp

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 July 31, 2016. Contact your State for more information on eligibility –

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

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

ALABAMA – Medicaid

Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: www.myakhipp.com
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: www.myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado & Child Health Plan Plus (CHP+)

Health First Colorado Website: www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid

Website: www.flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: www.dch.georgia.gov/medicaid
-*Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)*
Phone: 404-656-4507

MAINE – Medicaid

Website:
www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64:
Website: www.in.gov/fssa/hip Phone: 1-877-438-4479
All other Medicaid:
Website: indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid

Website: www.dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: www.kdheks.gov/hcf
Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: www.chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

NEW HAMPSHIRE – Medicaid

Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
state.nj.us/humanservices/dmahs/clients/medicaid
Medicaid Phone: 609-631-2392
CHIP Website: njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

MASSACHUSETTS – Medicaid and CHIP

Website:
www.mass.gov/MassHealth

MINNESOTA – Medicaid

Website: mn.gov/dhs/people-we-serve/seniors/health-care/ health-care-programs/programs-and-services/medical- assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website:
www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone:

MONTANA – Medicaid

Website:
dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website:
www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000

NEVADA – Medicaid

Medicaid Website: dwss.nv.gov/Medicaid
Phone: 1-800-992-0900

SOUTH CAROLINA – Medicaid

Website:
http://www.scdhhs.gov

SOUTH DAKOTA - Medicaid

Website: dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: gethipptexas.com
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: medicaid.utah.gov
CHIP: health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: www.greenmountaincare.org
Phone: 1-800-250-8427

NEW YORK – Medicaid

Website: www.health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: dma.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website:
www.nd.gov/dhs/services/medicalserv/medicaid

OKLAHOMA – Medicaid and CHIP

Website:
www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website:
healthcare.oregon.gov/Pages/index.aspx
www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website:
www.eohhs.ri.gov/

VIRGINIA – Medicaid and CHIP

Medicaid Website:
www.coverva.org/ programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
www.coverva.org/
programs_premium_assistance.cfm CHIP Phone: 1-

WASHINGTON – Medicaid

Website: www.hca.wa.gov/free-or-low-cost-health-care/ program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: mywvhipp.com
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and

Website:
dhs.wisconsin.gov/publications/p1/p10095.pdf Phone:

WYOMING – Medicaid

Website: wyequalitycare.acs-inc.com/ Phone: 307-777-7531

Group Plan
New Hire Enrollment & Change Form
Please Print

UMR
A United-Healthcare Group Company

Employer Information

Employer: BERLIN AREA SCHOOL DISTRICT Group Number 76-440246

☐ NEW ENROLLMENT ☐ CHANGE Effective Date of Coverage ______________________ Date of Hire: ________________________

Employee Information

Last Name	First Name	MI	Sex ☐ Male ☐ Female	Date of Birth	ID No. or Social Security No.
Street Address	City		State	Zip Code	Cell or Home Phone

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed
Date:_______________ Date:___________________ Date:_________________ Date:___________________

Coverage Type

I AM ENROLLING IN THE FOLLOWING COVERAGES:

MEDICAL *(Choose One)*

PLAN 1 - HRA
☐ Single
☐ Family

PLAN 2 - HSA
☐ Single
☐ Family

I hereby apply for coverage & authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage

I AM WAIVING COVERAGE FOR:

MEDICAL
☐ Single
☐ Family

If waiving coverage, I understand that entrance in the plan may be limited if I choose to apply for such coverage at a later date.

I AM REQUESTING THE FOLLOWING CHANGES:

☐ **DROP; Reason:** ☐ Divorce; ☐ Legal Separation; ☐ Voluntarily Drop
Address of dropped spouse/dependent: ________________________________
____

☐ Widowed; Date: ____

☐ **ADD; Reason:** ☐ Spouse, due to marriage ☐ Newborn ☐ Adoption
☐ Placed for Adoption ☐ Step Child ☐ Grandchild ☐ Loss of other coverage

☐ **Other** ____

☐ **Date of Event**___________________________

Dependent Information

Spouse's Last Name	First Name	MI	Sex: ☐ Male ☐ Female	Spouse's Date of Birth
Spouse's Employer (Complete Name & Address)				Spouse's Social Security #

DEPENDENT CHILDREN INFORMATION

Last Name	First Name	Middle Initial	Sex	Date of Birth	Social Security No.	Relationship to Employee

Additional Information

1. Are you or any dependent covered under Medicare? ☐ Yes ☐ No; Person(s) Name(s) ______________________________
Medicare ID No(s) ______________________________ Eff Date(s) ______________________________
2. Do you or any dependents have any other MEDICAL coverage? ☐ Yes ☐ No; Covered Individual(s) ______________________
Policy No. ____________________ Company Name ___________________________ Policy Holder ______________________

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. I understand that I may not change the coverage elections that I make unless there is a qualifying event or until the next open enrollment.

EMPLOYEE SIGNATURE: ____ **DATE:** ________________________

PLEASE RETURN THIS FORM TO YOUR EMPLOYER FOR APPROVAL AND PROCESSING.

(over)

Women's Health and Cancer Rights Act Notice

On October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998. As part of our plan's compliance with this Act, we are required to provide you with this enrollment notice outlining the coverage that this law requires our plan to provide.

The WCA Group Health Trust has always provided coverage for medically necessary mastectomies. This coverage includes procedures to reconstruct the breast on which the mastectomy was performed, as well as the cost of necessary prostheses (implants, special bras, etc.) and treatment of any physical complications resulting from any stage of the mastectomy. However, as a result of this federal law, the plan now provides coverage for surgery and reconstruction of the other breast to achieve a symmetrical appearance with the breast on which the mastectomy is performed.

The following benefits are required to be provided if benefits are provided for a mastectomy:

1. Coverage for reconstruction of the breast on which the mastectomy is performed.
2. Coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance with the breast on which the mastectomy is performed.
3. Coverage for prostheses and physical complications resulting for any state of the mastectomy, including lymphedemas.

These benefits are subject to the same deductible, copays and coinsurance that apply to mastectomy benefits under this plan.

Delta Dental of Wisconsin

Enrollment/Change/Waiver Form - Dental

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

EMPLOYER USE ONLY

GROUP NUMBER ______________________ EFFECTIVE DATE __________

COMPLETE THIS SECTION IF YOU ARE ACCEPTING, CHANGING, OR TERMINATING COVERAGE

EMPLOYEE LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	DATE OF BIRTH (M/D/Y)	GENDER F | M | U

HOME ADDRESS - STREET	CITY	STATE	ZIP

EMPLOYER NAME	EMPLOYER LOCATION	CITY	STATE	DATE OF HIRE (M/D/Y)

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

SPOUSE LAST NAME (IF DIFFERENT)	FIRST	M.I.	GENDER F	M	U	DATE OF BIRTH (M/D/Y)
CHILD/DEPENDENT LAST NAME (IF DIFFERENT)						

REASON FOR SUBMITTING THIS FORM

NEW ENROLLEE REHIRE (Date: ______________)

IF THIS IS FOR CHANGE, WHAT IS THE REASON? Date Occurred

- Birth/Adoption (Name:______________) ________
- Marriage/ Divorce ________
- Add/ Drop Dependent (Name: ______________) ________
- Termination of Benefits (Reason: ______________) ________
- Loss of Dental Benefits ________
- Name Change (Former Name: ______________) ________
- Address Change (______________) ________
- Group Transfer (From ________ To ________) ________
- COBRA Application ________

COVERAGE TYPE

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

- Employee Only
- Employee & Spouse
- Employee & Child(ren)
- Entire Family

YOUR MARITAL STATUS Single Married

If you are not accepting coverage for your spouse or dependents, are they covered by another dental plan?
Yes No

ACCEPT COVERAGE **High Plan** **Low Plan**

X ______________________ ________
Signature is Required Date

COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING COVERAGE

EMPLOYEE LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID

EMPLOYER NAME	EMPLOYER LOCATION	CITY	STATE

PLEASE CHECK ONE:

- I have coverage through my spouse
- I have other dental coverage
- I do not have other dental coverage

WAIVE COVERAGE X ______________________ ________
Signature is Required Date

Acceptance of Coverage

I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Master Agreement to Provide Dental Benefits.

Waiver of Coverage

I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the applicable terms and conditions of the Master Agreement to Provide Dental Benefits, which may require additional limitations and waiting periods. I also understand that Delta Dental of Wisconsin, Inc. reserves the right to reject such an application.

Enrollment Form with Dependent Data

Name of group (employer): ______________________________

Employee last name, first name, middle initial: ______________________________

Social Security Number: ______________________________

Gender: ☐ male ☐ female Date of birth (month/date/year): ______________

Effective Date of Coverage: ______________________

Type of coverage selected:
☐ employee only
☐ employee and one dependent
☐ employee and child(ren)
☐ employee and family
☐ waive coverage

* **Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /

Employee Signature: ______________________________

Please return this form to your benefits administrator. Do not return to VSP.

Standard Insurance Company

Enrollment and Change

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
164625			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Name Change Former Name ____________________

☐ Add Dependent ☐ Delete Dependent Date of Add/Delete ____________________

☐ Beneficiary Change ***Complete Beneficiary Section***

Your Full Name		Social Security Number	Birth Date	
Address		City	State	ZIP
Phone Number		Job Title/Occupation	☐ Male ☐ Female	
Employer Name **Berlin Area School District**		Hours Worked Per Week		
Earnings $__________	Per: ☐ Hour ☐ Week ☐ Month ☐ Year			
Spouse Full Name			Birth Date	

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements.

Life Insurance

☑ Basic Life with AD&D (Employer Paid)

You may choose one of the following options:

☐ Additional Life (Employee Paid) requested amount $__________

☐ Additional Life with AD&D (Employee Paid) requested amount $__________

Dependents Life Insurance

You may choose one of the following options for your Spouse:

☐ Spouse Life (Employee Paid) requested amount $__________

☐ Spouse Life with AD&D (Employee Paid) requested amount $__________

You may choose one of the following options for your Child(ren):

☐ Child(ren) Life (Employee Paid) requested amount $__________

☐ Child(ren) Life with AD&D (Employee Paid) requested amount $5,000

Short Term Disability Insurance

☐ Short Term Disability (Employee Paid) plan option requested __________

Long Term Disability Insurance

☑ Long Term Disability (Employer Paid)

Your Full Name

Beneficiary

This designation applies to your Life and Accidental Death and Dismemberment Insurance, if any, available through your Employer. Unless specified otherwise on a separate sheet of paper, this designation also will apply to your Supplemental Life and Accident Insurance, if any, available through your Employer, unless replaced by a separate and later designation. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.

Primary — Full Name	Address	DOB	Phone No.	SSN *if known*	Relationship	% of Benefit*
Contingent — Full Name	**Address**	**DOB**	**Phone No.**	**SSN *if known***	**Relationship**	**% of Benefit***

*Total must equal 100%

Signature

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. I represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement and my coverage will be subject to all terms and conditions of the Group Policy(ies).

Signature of Applicant (Member/Employee)	Date

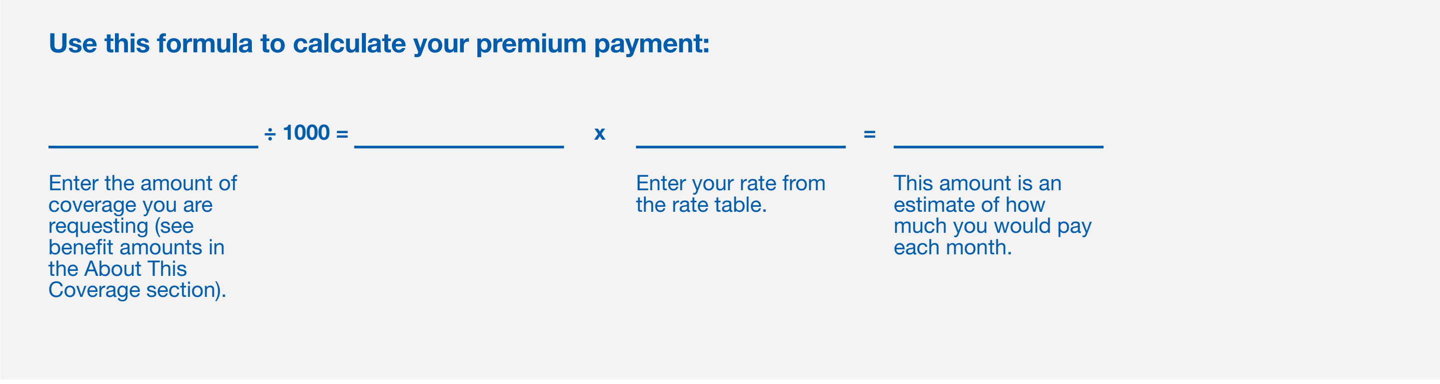
Your Full Name

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated ______________________."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

How Much Your Coverage Costs

Your Basic Life insurance is paid for by Berlin Area School District. If you choose to purchase Additional Life coverage, you'll have access to competitive group rates, which may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and the benefit amount.



Use this formula to calculate your premium payment:

__________ ÷ 1000 = __________ x __________ = __________

Enter the amount of coverage you are requesting (see benefit amounts in the About This Coverage section).

Enter your rate from the rate table.

This amount is an estimate of how much you would pay each month.

If you buy coverage for your spouse, your monthly rate is shown in the table below. Use the same formula to calculate the premium that you used for yourself, but use your spouse's age and your spouse's rate.

If you buy Dependents Life coverage for your child(ren), your monthly rate is $0.165 per $1,000, no matter how many children you're covering. If you elect AD&D insurance with your Dependents Life insurance for your child(ren), your child(ren)'s monthly AD&D rate is $0.04 per $1,000 added to the above rate.

Your Age (as of July 1)	Your Rate* (Per $1,000 of Total Coverage)
<30	$0.07
30–34	$0.08
35–39	$0.10
40–44	$0.15
45–49	$0.25
50–54	$0.41
55–59	$0.64
60–64	$0.98
65–69	$1.32
70+	$3.33

Spouse's Age (as of July 1)	Spouse's Rate** (Per $1,000 of Total Coverage)
<30	$0.07
30–34	$0.08
35–39	$0.10
40–44	$0.15
45–49	$0.25
50–54	$0.41
55–59	$0.64
60–64	$0.98
65–69	$1.32
70+	$3.33

*If you elect AD&D insurance with your Additional Life insurance, your monthly AD&D rate is $0.02 per $1,000 of AD&D benefit added to the above rates.

**If you elect AD&D insurance with your Dependents Life insurance for your spouse, your spouse's monthly AD&D rate is $0.02 per $1,000 of AD&D benefit added to the above rates.

Employee Life Monthly Premiums

Coverage Amount	Employee's Age as of July 1 < 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*	75-79*	80+*
$10,000	0.70	0.80	1.00	1.50	2.50	4.10	6.40	9.80	13.20	21.65	14.99	9.99
$20,000	1.40	1.60	2.00	3.00	5.00	8.20	12.80	19.60	26.40	43.29	29.97	19.98
$30,000	2.10	2.40	3.00	4.50	7.50	12.30	19.20	29.40	39.60	64.94	44.96	29.97
$40,000	2.80	3.20	4.00	6.00	10.00	16.40	25.60	39.20	52.80	86.58	59.94	39.96
$50,000	3.50	4.00	5.00	7.50	12.50	20.50	32.00	49.00	66.00	108.23	74.93	49.95
$60,000	4.20	4.80	6.00	9.00	15.00	24.60	38.40	58.80	79.20	129.87	89.91	59.94
$70,000	4.90	5.60	7.00	10.50	17.50	28.70	44.80	68.60	92.40	151.52	104.90	69.93
$80,000	5.60	6.40	8.00	12.00	20.00	32.80	51.20	78.40	105.60	173.16	119.88	79.92
$90,000	6.30	7.20	9.00	13.50	22.50	36.90	57.60	88.20	118.80	194.81	134.87	89.91
$100,000	7.00	8.00	10.00	15.00	25.00	41.00	64.00	98.00	132.00	216.45	149.85	99.90
$110,000	7.70	8.80	11.00	16.50	27.50	45.10	70.40	107.80	145.20	238.10	164.84	109.89
$120,000	8.40	9.60	12.00	18.00	30.00	49.20	76.80	117.60	158.40	259.74	179.82	119.88
$130,000	9.10	10.40	13.00	19.50	32.50	53.30	83.20	127.40	171.60	281.39	194.81	129.87
$140,000	9.80	11.20	14.00	21.00	35.00	57.40	89.60	137.20	184.80	303.03	209.79	139.86
$150,000	10.50	12.00	15.00	22.50	37.50	61.50	96.00	147.00	198.00	324.68	224.78	149.85
$160,000	11.20	12.80	16.00	24.00	40.00	65.60	102.40	156.80	211.20	346.32	239.76	159.84
$170,000	11.90	13.60	17.00	25.50	42.50	69.70	108.80	166.60	224.40	367.97	254.75	169.83
$180,000	12.60	14.40	18.00	27.00	45.00	73.80	115.20	176.40	237.60	389.61	269.73	179.82
$190,000	13.30	15.20	19.00	28.50	47.50	77.90	121.60	186.20	250.80	411.26	284.72	189.81
$200,000	14.00	16.00	20.00	30.00	50.00	82.00	128.00	196.00	264.00	432.90	299.70	199.80
$210,000	14.70	16.80	21.00	31.50	52.50	86.10	134.40	205.80	277.20	454.55	314.69	209.79
$220,000	15.40	17.60	22.00	33.00	55.00	90.20	140.80	215.60	290.40	476.19	329.67	219.78
$230,000	16.10	18.40	23.00	34.50	57.50	94.30	147.20	225.40	303.60	497.84	344.66	229.77
$240,000	16.80	19.20	24.00	36.00	60.00	98.40	153.60	235.20	316.80	519.48	359.64	239.76
$250,000	17.50	20.00	25.00	37.50	62.50	102.50	160.00	245.00	330.00	541.13	374.63	249.75
$260,000	18.20	20.80	26.00	39.00	65.00	106.60	166.40	254.80	343.20	562.77	389.61	259.74
$270,000	18.90	21.60	27.00	40.50	67.50	110.70	172.80	264.60	356.40	584.42	404.60	269.73
$280,000	19.60	22.40	28.00	42.00	70.00	114.80	179.20	274.40	369.60	606.06	419.58	279.72
$290,000	20.30	23.20	29.00	43.50	72.50	118.90	185.60	284.20	382.80	627.71	434.57	289.71
$300,000	21.00	24.00	30.00	45.00	75.00	123.00	192.00	294.00	396.00	649.35	449.55	299.70
$310,000	21.70	24.80	31.00	46.50	77.50	127.10	198.40	303.80	409.20	671.00	464.54	309.69
$320,000	22.40	25.60	32.00	48.00	80.00	131.20	204.80	313.60	422.40	692.64	479.52	319.68
$330,000	23.10	26.40	33.00	49.50	82.50	135.30	211.20	323.40	435.60	714.29	494.51	329.67
$340,000	23.80	27.20	34.00	51.00	85.00	139.40	217.60	333.20	448.80	735.93	509.49	339.66
$350,000	24.50	28.00	35.00	52.50	87.50	143.50	224.00	343.00	462.00	757.58	524.48	349.65
$360,000	25.20	28.80	36.00	54.00	90.00	147.60	230.40	352.80	475.20	779.22	539.46	359.64
$370,000	25.90	29.60	37.00	55.50	92.50	151.70	236.80	362.60	488.40	800.87	554.45	369.63
$380,000	26.60	30.40	38.00	57.00	95.00	155.80	243.20	372.40	501.60	822.51	569.43	379.62
$390,000	27.30	31.20	39.00	58.50	97.50	159.90	249.60	382.20	514.80	844.16	584.42	389.61
$400,000	28.00	32.00	40.00	60.00	100.00	164.00	256.00	392.00	528.00	865.80	599.40	399.60
$410,000	28.70	32.80	41.00	61.50	102.50	168.10	262.40	401.80	541.20	887.45	614.39	409.59
$420,000	29.40	33.60	42.00	63.00	105.00	172.20	268.80	411.60	554.40	909.09	629.37	419.58
$430,000	30.10	34.40	43.00	64.50	107.50	176.30	275.20	421.40	567.60	930.74	644.36	429.57
$440,000	30.80	35.20	44.00	66.00	110.00	180.40	281.60	431.20	580.80	952.38	659.34	439.56
$450,000	31.50	36.00	45.00	67.50	112.50	184.50	288.00	441.00	594.00	974.03	674.33	449.55
$460,000	32.20	36.80	46.00	69.00	115.00	188.60	294.40	450.80	607.20	995.67	689.31	459.54
$470,000	32.90	37.60	47.00	70.50	117.50	192.70	300.80	460.60	620.40	1,017.32	704.30	469.53
$480,000	33.60	38.40	48.00	72.00	120.00	196.80	307.20	470.40	633.60	1,038.96	719.28	479.52
$490,000	34.30	39.20	49.00	73.50	122.50	200.90	313.60	480.20	646.80	1,060.61	734.27	489.51
$500,000	35.00	40.00	50.00	75.00	125.00	205.00	320.00	490.00	660.00	1,082.25	749.25	499.50

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).

Employee Life **with AD&D** Monthly Premiums

Coverage Amount	Employee's Age as of July 1											
	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*	75-79*	80+*
$10,000	0.90	1.00	1.20	1.70	2.70	4.30	6.60	10.00	13.40	21.78	15.08	10.05
$20,000	1.80	2.00	2.40	3.40	5.40	8.60	13.20	20.00	26.80	43.55	30.15	20.10
$30,000	2.70	3.00	3.60	5.10	8.10	12.90	19.80	30.00	40.20	65.33	45.23	30.15
$40,000	3.60	4.00	4.80	6.80	10.80	17.20	26.40	40.00	53.60	87.10	60.30	40.20
$50,000	4.50	5.00	6.00	8.50	13.50	21.50	33.00	50.00	67.00	108.88	75.38	50.25
$60,000	5.40	6.00	7.20	10.20	16.20	25.80	39.60	60.00	80.40	130.65	90.45	60.30
$70,000	6.30	7.00	8.40	11.90	18.90	30.10	46.20	70.00	93.80	152.43	105.53	70.35
$80,000	7.20	8.00	9.60	13.60	21.60	34.40	52.80	80.00	107.20	174.20	120.60	80.40
$90,000	8.10	9.00	10.80	15.30	24.30	38.70	59.40	90.00	120.60	195.98	135.68	90.45
$100,000	9.00	10.00	12.00	17.00	27.00	43.00	66.00	100.00	134.00	217.75	150.75	100.50
$110,000	9.90	11.00	13.20	18.70	29.70	47.30	72.60	110.00	147.40	239.53	165.83	110.55
$120,000	10.80	12.00	14.40	20.40	32.40	51.60	79.20	120.00	160.80	261.30	180.90	120.60
$130,000	11.70	13.00	15.60	22.10	35.10	55.90	85.80	130.00	174.20	283.08	195.98	130.65
$140,000	12.60	14.00	16.80	23.80	37.80	60.20	92.40	140.00	187.60	304.85	211.05	140.70
$150,000	13.50	15.00	18.00	25.50	40.50	64.50	99.00	150.00	201.00	326.63	226.13	150.75
$160,000	14.40	16.00	19.20	27.20	43.20	68.80	105.60	160.00	214.40	348.40	241.20	160.80
$170,000	15.30	17.00	20.40	28.90	45.90	73.10	112.20	170.00	227.80	370.18	256.28	170.85
$180,000	16.20	18.00	21.60	30.60	48.60	77.40	118.80	180.00	241.20	391.95	271.35	180.90
$190,000	17.10	19.00	22.80	32.30	51.30	81.70	125.40	190.00	254.60	413.73	286.43	190.95
$200,000	18.00	20.00	24.00	34.00	54.00	86.00	132.00	200.00	268.00	435.50	301.50	201.00
$210,000	18.90	21.00	25.20	35.70	56.70	90.30	138.60	210.00	281.40	457.28	316.58	211.05
$220,000	19.80	22.00	26.40	37.40	59.40	94.60	145.20	220.00	294.80	479.05	331.65	221.10
$230,000	20.70	23.00	27.60	39.10	62.10	98.90	151.80	230.00	308.20	500.83	346.73	231.15
$240,000	21.60	24.00	28.80	40.80	64.80	103.20	158.40	240.00	321.60	522.60	361.80	241.20
$250,000	22.50	25.00	30.00	42.50	67.50	107.50	165.00	250.00	335.00	544.38	376.88	251.25
$260,000	23.40	26.00	31.20	44.20	70.20	111.80	171.60	260.00	348.40	566.15	391.95	261.30
$270,000	24.30	27.00	32.40	45.90	72.90	116.10	178.20	270.00	361.80	587.93	407.03	271.35
$280,000	25.20	28.00	33.60	47.60	75.60	120.40	184.80	280.00	375.20	609.70	422.10	281.40
$290,000	26.10	29.00	34.80	49.30	78.30	124.70	191.40	290.00	388.60	631.48	437.18	291.45
$300,000	27.00	30.00	36.00	51.00	81.00	129.00	198.00	300.00	402.00	653.25	452.25	301.50
$310,000	27.90	31.00	37.20	52.70	83.70	133.30	204.60	310.00	415.40	675.03	467.33	311.55
$320,000	28.80	32.00	38.40	54.40	86.40	137.60	211.20	320.00	428.80	696.80	482.40	321.60
$330,000	29.70	33.00	39.60	56.10	89.10	141.90	217.80	330.00	442.20	718.58	497.48	331.65
$340,000	30.60	34.00	40.80	57.80	91.80	146.20	224.40	340.00	455.60	740.35	512.55	341.70
$350,000	31.50	35.00	42.00	59.50	94.50	150.50	231.00	350.00	469.00	762.13	527.63	351.75
$360,000	32.40	36.00	43.20	61.20	97.20	154.80	237.60	360.00	482.40	783.90	542.70	361.80
$370,000	33.30	37.00	44.40	62.90	99.90	159.10	244.20	370.00	495.80	805.68	557.78	371.85
$380,000	34.20	38.00	45.60	64.60	102.60	163.40	250.80	380.00	509.20	827.45	572.85	381.90
$390,000	35.10	39.00	46.80	66.30	105.30	167.70	257.40	390.00	522.60	849.23	587.93	391.95
$400,000	36.00	40.00	48.00	68.00	108.00	172.00	264.00	400.00	536.00	871.00	603.00	402.00
$410,000	36.90	41.00	49.20	69.70	110.70	176.30	270.60	410.00	549.40	892.78	618.08	412.05
$420,000	37.80	42.00	50.40	71.40	113.40	180.60	277.20	420.00	562.80	914.55	633.15	422.10
$430,000	38.70	43.00	51.60	73.10	116.10	184.90	283.80	430.00	576.20	936.33	648.23	432.15
$440,000	39.60	44.00	52.80	74.80	118.80	189.20	290.40	440.00	589.60	958.10	663.30	442.20
$450,000	40.50	45.00	54.00	76.50	121.50	193.50	297.00	450.00	603.00	979.88	678.38	452.25
$460,000	41.40	46.00	55.20	78.20	124.20	197.80	303.60	460.00	616.40	1,001.65	693.45	462.30
$470,000	42.30	47.00	56.40	79.90	126.90	202.10	310.20	470.00	629.80	1,023.43	708.53	472.35
$480,000	43.20	48.00	57.60	81.60	129.60	206.40	316.80	480.00	643.20	1,045.20	723.60	482.40
$490,000	44.10	49.00	58.80	83.30	132.30	210.70	323.40	490.00	656.60	1,066.98	738.68	492.45
$500,000	45.00	50.00	60.00	85.00	135.00	215.00	330.00	500.00	670.00	1,088.75	753.75	502.50

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).

Spouse Life Monthly Premiums

Coverage	Spouse's Age as of July 1											
Amount	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*	75-79*	80+*
$5,000	0.35	0.40	0.50	0.75	1.25	2.05	3.20	4.90	6.60	10.82	7.49	5.00
$10,000	0.70	0.80	1.00	1.50	2.50	4.10	6.40	9.80	13.20	21.65	14.99	9.99
$15,000	1.05	1.20	1.50	2.25	3.75	6.15	9.60	14.70	19.80	32.47	22.48	14.99
$20,000	1.40	1.60	2.00	3.00	5.00	8.20	12.80	19.60	26.40	43.29	29.97	19.98
$25,000	1.75	2.00	2.50	3.75	6.25	10.25	16.00	24.50	33.00	54.11	37.46	24.98
$30,000	2.10	2.40	3.00	4.50	7.50	12.30	19.20	29.40	39.60	64.94	44.96	29.97
$35,000	2.45	2.80	3.50	5.25	8.75	14.35	22.40	34.30	46.20	75.76	52.45	34.97
$40,000	2.80	3.20	4.00	6.00	10.00	16.40	25.60	39.20	52.80	86.58	59.94	39.96
$45,000	3.15	3.60	4.50	6.75	11.25	18.45	28.80	44.10	59.40	97.40	67.43	44.96
$50,000	3.50	4.00	5.00	7.50	12.50	20.50	32.00	49.00	66.00	108.23	74.93	49.95
$55,000	3.85	4.40	5.50	8.25	13.75	22.55	35.20	53.90	72.60	119.05	82.42	54.95
$60,000	4.20	4.80	6.00	9.00	15.00	24.60	38.40	58.80	79.20	129.87	89.91	59.94
$65,000	4.55	5.20	6.50	9.75	16.25	26.65	41.60	63.70	85.80	140.69	97.40	64.94
$70,000	4.90	5.60	7.00	10.50	17.50	28.70	44.80	68.60	92.40	151.52	104.90	69.93
$75,000	5.25	6.00	7.50	11.25	18.75	30.75	48.00	73.50	99.00	162.34	112.39	74.93
$80,000	5.60	6.40	8.00	12.00	20.00	32.80	51.20	78.40	105.60	173.16	119.88	79.92
$85,000	5.95	6.80	8.50	12.75	21.25	34.85	54.40	83.30	112.20	183.98	127.37	84.92
$90,000	6.30	7.20	9.00	13.50	22.50	36.90	57.60	88.20	118.80	194.81	134.87	89.91
$95,000	6.65	7.60	9.50	14.25	23.75	38.95	60.80	93.10	125.40	205.63	142.36	94.91
$100,000	7.00	8.00	10.00	15.00	25.00	41.00	64.00	98.00	132.00	216.45	149.85	99.90
$105,000	7.35	8.40	10.50	15.75	26.25	43.05	67.20	102.90	138.60	227.27	157.34	104.90
$110,000	7.70	8.80	11.00	16.50	27.50	45.10	70.40	107.80	145.20	238.10	164.84	109.89
$115,000	8.05	9.20	11.50	17.25	28.75	47.15	73.60	112.70	151.80	248.92	172.33	114.89
$120,000	8.40	9.60	12.00	18.00	30.00	49.20	76.80	117.60	158.40	259.74	179.82	119.88
$125,000	8.75	10.00	12.50	18.75	31.25	51.25	80.00	122.50	165.00	270.56	187.31	124.88
$130,000	9.10	10.40	13.00	19.50	32.50	53.30	83.20	127.40	171.60	281.39	194.81	129.87
$135,000	9.45	10.80	13.50	20.25	33.75	55.35	86.40	132.30	178.20	292.21	202.30	134.87
$140,000	9.80	11.20	14.00	21.00	35.00	57.40	89.60	137.20	184.80	303.03	209.79	139.86
$145,000	10.15	11.60	14.50	21.75	36.25	59.45	92.80	142.10	191.40	313.85	217.28	144.86
$150,000	10.50	12.00	15.00	22.50	37.50	61.50	96.00	147.00	198.00	324.68	224.78	149.85
$155,000	10.85	12.40	15.50	23.25	38.75	63.55	99.20	151.90	204.60	335.50	232.27	154.85
$160,000	11.20	12.80	16.00	24.00	40.00	65.60	102.40	156.80	211.20	346.32	239.76	159.84
$165,000	11.55	13.20	16.50	24.75	41.25	67.65	105.60	161.70	217.80	357.14	247.25	164.84
$170,000	11.90	13.60	17.00	25.50	42.50	69.70	108.80	166.60	224.40	367.97	254.75	169.83
$175,000	12.25	14.00	17.50	26.25	43.75	71.75	112.00	171.50	231.00	378.79	262.24	174.83
$180,000	12.60	14.40	18.00	27.00	45.00	73.80	115.20	176.40	237.60	389.61	269.73	179.82
$185,000	12.95	14.80	18.50	27.75	46.25	75.85	118.40	181.30	244.20	400.43	277.22	184.82
$190,000	13.30	15.20	19.00	28.50	47.50	77.90	121.60	186.20	250.80	411.26	284.72	189.81
$195,000	13.65	15.60	19.50	29.25	48.75	79.95	124.80	191.10	257.40	422.08	292.21	194.81
$200,000	14.00	16.00	20.00	30.00	50.00	82.00	128.00	196.00	264.00	432.90	299.70	199.80
$205,000	14.35	16.40	20.50	30.75	51.25	84.05	131.20	200.90	270.60	443.72	307.19	204.80
$210,000	14.70	16.80	21.00	31.50	52.50	86.10	134.40	205.80	277.20	454.55	314.69	209.79
$215,000	15.05	17.20	21.50	32.25	53.75	88.15	137.60	210.70	283.80	465.37	322.18	214.79
$220,000	15.40	17.60	22.00	33.00	55.00	90.20	140.80	215.60	290.40	476.19	329.67	219.78
$225,000	15.75	18.00	22.50	33.75	56.25	92.25	144.00	220.50	297.00	487.01	337.16	224.78
$230,000	16.10	18.40	23.00	34.50	57.50	94.30	147.20	225.40	303.60	497.84	344.66	229.77
$235,000	16.45	18.80	23.50	35.25	58.75	96.35	150.40	230.30	310.20	508.66	352.15	234.77
$240,000	16.80	19.20	24.00	36.00	60.00	98.40	153.60	235.20	316.80	519.48	359.64	239.76
$245,000	17.15	19.60	24.50	36.75	61.25	100.45	156.80	240.10	323.40	530.30	367.13	244.76
$250,000	17.50	20.00	25.00	37.50	62.50	102.50	160.00	245.00	330.00	541.13	374.63	249.75

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).

Spouse Life **with AD&D** Monthly Premiums

Coverage Amount	Spouse's Age as of July 1 < 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*	75-79*	80+*
$5,000	0.45	0.50	0.60	0.85	1.35	2.15	3.30	5.00	6.70	10.89	7.54	5.03
$10,000	0.90	1.00	1.20	1.70	2.70	4.30	6.60	10.00	13.40	21.78	15.08	10.05
$15,000	1.35	1.50	1.80	2.55	4.05	6.45	9.90	15.00	20.10	32.66	22.61	15.08
$20,000	1.80	2.00	2.40	3.40	5.40	8.60	13.20	20.00	26.80	43.55	30.15	20.10
$25,000	2.25	2.50	3.00	4.25	6.75	10.75	16.50	25.00	33.50	54.44	37.69	25.13
$30,000	2.70	3.00	3.60	5.10	8.10	12.90	19.80	30.00	40.20	65.33	45.23	30.15
$35,000	3.15	3.50	4.20	5.95	9.45	15.05	23.10	35.00	46.90	76.21	52.76	35.18
$40,000	3.60	4.00	4.80	6.80	10.80	17.20	26.40	40.00	53.60	87.10	60.30	40.20
$45,000	4.05	4.50	5.40	7.65	12.15	19.35	29.70	45.00	60.30	97.99	67.84	45.23
$50,000	4.50	5.00	6.00	8.50	13.50	21.50	33.00	50.00	67.00	108.88	75.38	50.25
$55,000	4.95	5.50	6.60	9.35	14.85	23.65	36.30	55.00	73.70	119.76	82.91	55.28
$60,000	5.40	6.00	7.20	10.20	16.20	25.80	39.60	60.00	80.40	130.65	90.45	60.30
$65,000	5.85	6.50	7.80	11.05	17.55	27.95	42.90	65.00	87.10	141.54	97.99	65.33
$70,000	6.30	7.00	8.40	11.90	18.90	30.10	46.20	70.00	93.80	152.43	105.53	70.35
$75,000	6.75	7.50	9.00	12.75	20.25	32.25	49.50	75.00	100.50	163.31	113.06	75.38
$80,000	7.20	8.00	9.60	13.60	21.60	34.40	52.80	80.00	107.20	174.20	120.60	80.40
$85,000	7.65	8.50	10.20	14.45	22.95	36.55	56.10	85.00	113.90	185.09	128.14	85.43
$90,000	8.10	9.00	10.80	15.30	24.30	38.70	59.40	90.00	120.60	195.98	135.68	90.45
$95,000	8.55	9.50	11.40	16.15	25.65	40.85	62.70	95.00	127.30	206.86	143.21	95.48
$100,000	9.00	10.00	12.00	17.00	27.00	43.00	66.00	100.00	134.00	217.75	150.75	100.50
$105,000	9.45	10.50	12.60	17.85	28.35	45.15	69.30	105.00	140.70	228.64	158.29	105.53
$110,000	9.90	11.00	13.20	18.70	29.70	47.30	72.60	110.00	147.40	239.53	165.83	110.55
$115,000	10.35	11.50	13.80	19.55	31.05	49.45	75.90	115.00	154.10	250.41	173.36	115.58
$120,000	10.80	12.00	14.40	20.40	32.40	51.60	79.20	120.00	160.80	261.30	180.90	120.60
$125,000	11.25	12.50	15.00	21.25	33.75	53.75	82.50	125.00	167.50	272.19	188.44	125.63
$130,000	11.70	13.00	15.60	22.10	35.10	55.90	85.80	130.00	174.20	283.08	195.98	130.65
$135,000	12.15	13.50	16.20	22.95	36.45	58.05	89.10	135.00	180.90	293.96	203.51	135.68
$140,000	12.60	14.00	16.80	23.80	37.80	60.20	92.40	140.00	187.60	304.85	211.05	140.70
$145,000	13.05	14.50	17.40	24.65	39.15	62.35	95.70	145.00	194.30	315.74	218.59	145.73
$150,000	13.50	15.00	18.00	25.50	40.50	64.50	99.00	150.00	201.00	326.63	226.13	150.75
$155,000	13.95	15.50	18.60	26.35	41.85	66.65	102.30	155.00	207.70	337.51	233.66	155.78
$160,000	14.40	16.00	19.20	27.20	43.20	68.80	105.60	160.00	214.40	348.40	241.20	160.80
$165,000	14.85	16.50	19.80	28.05	44.55	70.95	108.90	165.00	221.10	359.29	248.74	165.83
$170,000	15.30	17.00	20.40	28.90	45.90	73.10	112.20	170.00	227.80	370.18	256.28	170.85
$175,000	15.75	17.50	21.00	29.75	47.25	75.25	115.50	175.00	234.50	381.06	263.81	175.88
$180,000	16.20	18.00	21.60	30.60	48.60	77.40	118.80	180.00	241.20	391.95	271.35	180.90
$185,000	16.65	18.50	22.20	31.45	49.95	79.55	122.10	185.00	247.90	402.84	278.89	185.93
$190,000	17.10	19.00	22.80	32.30	51.30	81.70	125.40	190.00	254.60	413.73	286.43	190.95
$195,000	17.55	19.50	23.40	33.15	52.65	83.85	128.70	195.00	261.30	424.61	293.96	195.98
$200,000	18.00	20.00	24.00	34.00	54.00	86.00	132.00	200.00	268.00	435.50	301.50	201.00
$205,000	18.45	20.50	24.60	34.85	55.35	88.15	135.30	205.00	274.70	446.39	309.04	206.03
$210,000	18.90	21.00	25.20	35.70	56.70	90.30	138.60	210.00	281.40	457.28	316.58	211.05
$215,000	19.35	21.50	25.80	36.55	58.05	92.45	141.90	215.00	288.10	468.16	324.11	216.08
$220,000	19.80	22.00	26.40	37.40	59.40	94.60	145.20	220.00	294.80	479.05	331.65	221.10
$225,000	20.25	22.50	27.00	38.25	60.75	96.75	148.50	225.00	301.50	489.94	339.19	226.13
$230,000	20.70	23.00	27.60	39.10	62.10	98.90	151.80	230.00	308.20	500.83	346.73	231.15
$235,000	21.15	23.50	28.20	39.95	63.45	101.05	155.10	235.00	314.90	511.71	354.26	236.18
$240,000	21.60	24.00	28.80	40.80	64.80	103.20	158.40	240.00	321.60	522.60	361.80	241.20
$245,000	22.05	24.50	29.40	41.65	66.15	105.35	161.70	245.00	328.30	533.49	369.34	246.23
$250,000	22.50	25.00	30.00	42.50	67.50	107.50	165.00	250.00	335.00	544.38	376.88	251.25

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).

Child Life Monthly Premium

Coverage Amount	Premium
$5,000	0.83

Child Life **with AD&D** Monthly Premium

Coverage Amount	Premium
$5,000	1.03